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FY 80 LEGISLATIVE RECOMMENDATIONS OF VETERANS' ORGANIZATIONS

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HEARINGS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST AND SECOND SESSIONS

ON

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1/23/81

LEGISLATIVE RECOMMENDATIONS OF NATIONAL COMMANDERS OF THE AMERICAN LEGION; DISABLED AMERICAN VETERANS; VETERANS OF FOREIGN WARS; VETERANS OF WORLD WAR I OF THE U.S.A., INC.; MILITARY ORDER OF THE PURPLE HEART; AMERICAN VETERANS OF WORLD WAR II, KOREA, AND VIETNAM (AMVETS); BLINDED VETERANS ASSOCIATION; AND PARALYZED VETERANS OF AMERICA

SEPTEMBER 26, 1979; FEBRUARY 26, AND MARCH 4 AND 27, 1980

#7079250

Printed for the use of the Committee on Veterans' Affairs

FY 80 LEGISLATIVE RECOMMENDATIONS OF VETERANS' ORGANIZATIONS

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SEPTEMBER 25, 1979; FEBRUARY 26, AND MARCH 4 AND 27, 1980

Printed for the use of the Committee on Veterans' Affairs

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FY 1980 LEGISLATIVE RECOMMENDATIONS OF VETERANS' ORGANIZATIONS

TUESDAY, SEPTEMBER 25, 1979

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 11 a.m., in room 5110, Dirksen Office Building, Hon. Alan Cranston (chairman of the committee) presiding.

Present: Chairman Alan Cranston (presiding), Senators Strom Thurmond, Robert T. Stafford, Alan K. Simpson, Jennings Randolph, John A. Durkin, and Gordon J. Humphrey.

OPENING STATEMENT OF HON. ALAN CRANSTON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman CRANSTON. This hearing will please come to order.

I want to welcome all of you here this morning for The American Legion's presentation of its legislative goals for the 2d session of the 96th Congress.

I am very pleased to welcome you, Commander Hamilton, and congratulate you on your recent election. Your 25-year record of service to The American Legion and to the Nation is most distinguished, and I am sure you will be a very capable successor to Commander Jack Carey, with whom I have had the pleasure of working closely during the 1st session of the 96th Congress. I am also pleased to welcome back Al Brown, chairman of national legislative commission, and Bill Lenker, chairman of the national veterans affairs and rehabilitation commission.

I would also like to congratulate all of the newly elected vice commanders and national officials and the new national president and vice president of The American Legion Auxiliary. I look forward to working together with each of you.

As you know, I had the great honor of receiving The American Legion's Distinguished Public Service Award at your recent convention in Houston. I cherish this award, and I am deeply grateful for your recognition. You may be sure that I will continue my efforts to safeguard the rights of our Nation's veterans. They must—and they will—receive all of the benefits to which they are so justly entitled.

At this point, before hearing your legislative goals, I would like to thank all of you in The American Legion for your great help to this committee during the past year. Your fine organization continues to render steadfast and truly fine service to all veterans and their survivors.

Your assistance was instrumental in achieving substantial improvements in the VA pension program at the end of the 95th Congress. Pensioners who have so far elected coverage in the new program, which became effective this past January, have realized increases on the average of 50 percent in their monthly pension payments.

Already this year we have enacted the Veterans' Health Care Amendments of 1979—Public Law 96-22—legislation we had worked on for 8 years. This new law provides for a readjustment counseling program for those Vietnam-era veterans who continue to have readjustment problems and need help to make the transition to civilian life.

It also improves the VA's ability to meet the needs of veterans with alcohol or drug abuse dependencies by authorizing the Administrator to contract with community based treatment facilities to provide care to such veterans. Alcoholism remains among the most frequent admissions diagnoses at VA hospitals, and I believe that Public Law 96-22 represents a major step in providing effective treatment for this major medical problem.

As you know, on August 3, the Senate passed H.R. 2282 to provide for an 11.1 percent cost-of-living increase in compensation benefits for service-connected disabled veterans and their survivors. We are presently working with our counterpart in the House to reconcile our differences on this legislation, and I will continue to work very hard to secure enactment of the best possible legislation.

In addition, this committee recently reported legislation to give thousands of Vietnam-era veterans who are unemployed, or who never finished high school, another 3 years in which to use their GI Bill benefits, and we are committed to pushing hard for a cost-of-living increase for GI Bill beneficiaries. We know we can count on your support in fighting for that increase and it will take a fight.

We are also, with the very able assistance of Legion officials here in Washington and in the field, working hard to assist veterans who were exposed to hazardous substances during their service—particularly low-level radiation from the atomic bomb tests in the 1950's and the chemical dioxin in agent orange during service in Vietnam.

A great deal of concern this year has centered on the VA health-care system. Let me emphasize that I am totally committed to a strong and independent VA medical system. We are in that battle together. And I will do everything in my power to maintain that system and assure that its ability to provide quality care to our Nation's veterans is protected.

Many of you have heard that the House Ways and Means Committee has approved an amendment to the hospital cost containment bill that would bring the VA under the proposed cost containment program in HEW. Your response to this amendment was swift and strong in opposition. Legion members from all over the country have let me know that they share your views. I want you to know that I am grateful for that support. With the help of the Legion, this committee and our counterpart in the House of Representatives will never let a proposal like that become law.

Again, with your help, the two Veterans' Affairs Committees have been successful in getting funds appropriated to hire 3,800 additional staff for the VA health-care system. These additional personnel will alleviate critical shortages in VA hospital staffing that are now impairing the provision of adequate health care in certain VA facilities. In fact, this increase will assure a VA staff-to-patient ratio for fiscal year 1980 that will be at an alltime high.

But, none of us can rest secure on this matter until the staffing is actually provided, and I want you to know that this committee and the House committee are planning an active monitoring effort both to make sure that these additional positions are actually provided and quickly filled—as Congress clearly intends—and to investigate the current non-service-connected treatment policies and practices of the VA medical system.

As most of you are aware, despite the very strong effort of the Legion, we suffered a disappointing blow during Senate consideration of the second concurrent resolution on the fiscal year 1980 budget. My amendment, which was cosponsored by eight other members of this committee, to add funds that we believe are absolutely essential for the adequate maintenance of veterans' programs—including entitlement and health-care programs—was defeated. The final outcome of this issue, however, must await the Senate-House conference on the budget resolution since the budget levels proposed by the House—thanks to the excellent work of our great friend, Ray Roberts—are far higher than the Senate levels. I urge you to continue your hard work on this issue.

Let me tell you here and now that we have not let up in our efforts to assure that, in the end, those very necessary increases for veterans' benefits and services will be part of the fiscal year 1980 budget that is approved by Congress. I am firmly convinced that this Nation cannot—and will not—go back on its promises of a fair cost-of-living increase in compensation benefits and responsive health-care services for its veterans.

In this crucial budget fight, I know I can count on your strong support. We need it.

I thank you for all your assistance during the 1st session of the 96th Congress—especially the fine work of Mylio Kraja, Bob Lyngh, Ed Lord, and Phil Riggin here in Washington. We will continue to need your help in the months ahead.

I would now like to call upon other members of the committee for their opening remarks and Alan, if you don't object I am going to go over you to Strom Thurmond. He is supposed to be on the floor handling a bill. I know he wants to return as soon as possible so we can give him an opportunity to speak.

Senator THURMOND. Mr. Chairman, it is a pleasure to be here today to receive the legislative recommendations of The American Legion. I want to welcome our National Commander Frank Hamilton to the Senate Veterans' Affairs Committee and to Washington. I notice he is flanked by both of his U.S. Senators and I am sure it is heartening to him to have both of these Senators here this morning.

It is also good to see Mr. Kraja, Mr. Lenker, Mr. Lyngh, and others with whom I worked on a regular basis throughout the year to establish and implement programs to benefit our Nation's veterans. Since I have been a member of this committee I have looked forward to your annual presentation of priority legislative goals and initiatives. Let me assure you, this committee gives close attention to the views and recommendations of The American Legion.

During August, I had the pleasure of attending our national convention in Houston, Tex., and addressed several of the commission meetings. Each commission member and Legionnaire should be commended for the hard work and dedication that was exhibited at this convention. Also, I would like to take this opportunity to commend the Legion for the fine work that is done throughout the year in the areas of veterans' rehabilitation and readjustment, youth programs, Americanism, and national security.

The past 9 months of the 96th Congress have been very busy with the Veterans' Committee being no exception. The VA hospital system has come under attack from several fronts. First, the administration's budget was lean and austere which contributed greatly to the reduction of staff in many hospitals and even the closing of several wards. I am pleased that additional money has been placed in the budget which I am hopeful will restore these much needed things.

Second, there has been an ever increasing effort to combine the VA hospital system with community based hospitals, thus permitting this VA system which was established for unique and courageous individuals who served this Nation when duty called, to be absorbed and managed by nonveteran agencies like HEW.

You can be assured that as long as I am in the Senate I will fight to maintain the VA hospital system for veterans and keep the tentacles of HEW from strangling our hospitals.

Several years ago, I was successful in establishing the Deputy Assistant Secretary of Labor for Veterans' Employment. This person is charged with administering the various programs within the Department of Labor which affects veterans.

At present, I believe the current DASVE is doing a good job. However, the status of veterans and their employment problems should be brought to a higher level of consideration. Consequently, I introduced S. 250 which would upgrade the DASVE to that of a full Assistant Secretary of Labor. I am pleased that the Legion shares this view and adopted resolution 100 which calls for the establishment of a full Assistant Secretary of Labor for Veterans' Employment.

Finally, no issue is more repugnant to the concept of rewarding one for faithful and honorable service than that of pending legislation S. 1041 which could grant veterans' benefits to deserters. Under current law, a person a.w.o.l. for at least 180 days and discharged under conditions other than honorable is statutorily barred from receiving VA benefits unless he can show to the Administrator that compelling circumstances existed to warrant such absence.

S. 1041 would remove this statutory bar to VA benefits and let the discharged review boards of the various services consider the discharges and upgrade them if warranted. Thus, dishonorable discharges would be considered by military personnel who would be under the command of the President and subject to his command orders. I am pleased the Legion has resolution 343 condemning S. 1041 and shares with me the belief that veterans' benefits should go to those who stood and not those who tucked their tails and ran.

I appreciate your presentations this morning and share your concern for the need to improve present veterans' programs and fulfill our Nations' commitment to provide for the veteran and his survivors. I would like to commend the Legion for electing as their national commander Frank Hamilton, a very able man, who I am sure will provide outstanding leadership to this great organization. I am very pleased to welcome here today the commander of the South Carolina department of The American Legion and as I call their names I wish they would stand, and please hold the applause until they are all recognized.

Former Congressman Bryan Dorn, our State commander, would you stand. Jim and Dot Hamilton, the State adjutant; Abe and Jewel Fennell, the editor of South Carolina Legionnaire; and Bill and Ruth Plowden, the veterans' employment service representative for South Carolina; other Legionnaires from South Carolina, would you please stand. Now, we can give them a hand.

I commend the South Carolina department for the great work they have done. We are very proud of them. I am glad to be a member of this great organization and pleased to assist you with your program.

Mr. Chairman, I need to get back to the Senate floor so if you will now excuse me. Thank you very much.

Chairman CRANSTON. Thank you, very much, Strom. I know you would stay here if you could. You have been an outstanding member of this committee throughout its life. I will now introduce Senator Randolph who likewise has been a very staunch defender and led so many battles on behalf of our veterans.

Senator RANDOLPH. Thank you, Mr. Chairman. I appreciate the directness of your statement, not one just of greeting but it has brought to the attention of the policymakers and thought leaders of The American Legion, the feeling that on this committee, regardless of party affiliation, the commitment to the veteran in the Senate of the United States and the House of Representatives.

Of course, I am delighted that our colleagues, the two Senators from Indiana, Birch Bayh and Dick Lugar, are here with their friend and constituent Frank Hamilton.

I am delighted to see William Jennings Bryan Dorn here this morning. It may be a long name but he is deserving of 10 names. I have known him through the years and I know of his support of the veteran while in the House of Representatives. I also wanted to speak of someone who is here today from other days in the House of Representatives, before I make a very brief statement.

We have here Robert Secrest.

Bob, would you stand?

Bob Secrest is from Senecaville, Ohio, just across the Ohio River from West Virginia. Bob and I came and were sworn in as Members of the United States House of Representatives on March 4, 1933. Thank you, Bob. You look good.

I commend also, of course, Senator Thurmond. I will not go into subjects on which we have agreement, on which statements have been made over and over from this side of the table on pending matters. We once again gather to receive the presentation of The American Legion. National Commander Frank Hamilton is accompanied, of course, by those leaders who hold important offices of responsibility in The American Legion.

I am sure it is not provincial for me to refer to a former national vice commander who comes from my hometown, or I come from his hometown. We live in the same hometown. Chester Phillips, will you stand, please?

We have had the same population year in and year out. Not much changes there except that people continue that commitment to the veterans of the United States of America. From that community, from that county, and also from the State of West Virgnia.

I personally think that it is not inappropriate for me to say that I have the support of the largest veterans' organization of the United States on matters that I have introduced and others have introduced.

We must always look to the expansion, if it is necessary, certainly always the improvement for those veterans' benefits that are valid and to the national security issues that go beyond the veteran although he and she are the core of that sort of situation.

I personally appreciate the support for two measures that I have introduced Senate Joint Resolution 39 and S. 517.

Senate Joint Resolution 39 would designate the second full calendar week in March of each year as National Employ the Older Worker Week.

We do have problems in connection with the older worker. And the older worker, of course, is often the veteran.

S. 517 would reestablish May 30 of each year as Memorial Day. This thing of affixing holidays as 3-day weekend is an atrocious action on the Congress of the people of the United States. If it means anything, the fourth of July is on the 4th of July.

If May 30 means anything, it is May 30. We have the same situation with November 11, as you know. And it was through veterans' organizations, Mr. Chairman, that we had much of the support to put Veterans' Day or Armistice Day back on November 11 and not set into some weekend. I think the Legion and all other veterans' organizations should realize that these memorials, you know, are not routine.

They are there because something happened on a certain day. Yes, in honor of those who have protected the freedoms of people in many generations of this country. We have difficult choices to make but as we have those legitimate and competing forces all around us, I know that the members of this committee and I hope the Members of the Senate and the House will never be reluctant. We will not diminish our commitment to the American veteran. Having said all this, believe me, I believe it.

Chairman CRANSTON. Thank you very much, Jennings, for that fighting about for what you believe in so very deeply.

Now, I recognize the ranking minority member of this committee, a new Member who has done outstanding work, assumed a role of leadership instantly and most effectively. It is a great pleasure to work with him, Senator Alan Simpson of Wyoming.

Senator SIMPSON. Thank you, very much, Mr. Chairman, and thank you for your patience, Senator Bayh and Senator Lugar. Your turn is coming. I appreciate your recognizing me. My remarks will be very brief.

I do want to join in extending a very warm welcome to the national commander of The American Legion and the various officers and members of this fine organization that are with us this morning. I congratulate you, Frank Hamilton upon your recent election to national commander.

And we, of this Senate Veterans' Affairs Committee look forward to working with you during your term of office and we appreciate the helpful cooperation that members of your professional staff of the Legion have given to our committee and we are grateful for the support of all the Legion members in our efforts on behalf of the American veterans. I concur in the remarks of our distinguished Chairman and Senator Thurmond and Senator Randolph and as ranking minority member of this committee I will continue to work closely with our very capable Chairman Alan Cranston and other members of the committee in recommending to the Congress, hopefully, the best possible legislative agenda which will advance the cause of the Nation's veterans and their widows and survivors.

And since you represent a leading organization of veterans, and I am a lifetime member of brand X veterans' organizations. I don't have a hat for this one. Your position and views are just as important as those of the Veterans of Foreign Wars and Disabled American Veterans and other very effective and efficient veterans groups.

And we appreciate your being here. We urge you to assist us in achieving our efforts. We are pleased to hear your legislative program for the year and thank you for your continuing support of this committee and welcome you to the committee.

Chairman CRANSTON. Now, to my left, Senator John Durkin of New Hampshire, another hard working and very effective member of this committee and a great friend of veterans.

Senator DURKIN. Thank you, Mr. Chairman.

Commander Hamilton, welcome. It is a pleasure to have you here this morning, and to see in your company my colleagues, Senator Bayh and Senator Lugar. We are very interested in what you have to say.

I am also very pleased to welcome Keith Fleury and Mike LaRocca, from my home State of New Hampshire. Could they stand up? Welcome, it is good to see you.

Commander, I have already reviewed a copy of your presentation and I just want to say that, as usual, The American Legion can count on my complete support. In this regard, I believe my record in this committee and on the Senate floor speaks for itself.

As the only member of the Senate on both the Veterans' Affairs and Appropriations Committees I am especially committed to GI Bill improvement and to protecting the quality of care and services provided through the Veterans' Administration. I strongly opposed the three modified cost-savings amendments—regarding beneficiary travel reimbursement, over-the-counter drugs and supplies, and dental care, that were approved by the Senate earlier this year. Just last week, I joined the hard working, dedicated Chairman, Senator Cranston, and a number of other members of this committee in cosponsoring a floor amendment to the budget resolution to increase the proposed totals for veterans' benefits and services by a much needed $300 million in budget authority and $400 million in outlays.

I could discuss that floor action at great length, but I think the basic thrust and crucial challenge we face is this; Congress must bring Government spending under control. However, this should not be done at the expense of those who have suffered most from the ravages of inflation and rising energy costs.

In my view, it is unconscionable to ask American veterans to shoulder the burden of our fight against inflation. They are victims, and certainly not the cause, of inflation. And so, as the chairman said, we are going to do everything possible to insure Senate-House budget conference agreement on function 700 that reflects our Nation's and the Congress special responsibility to those who have brought honor to the U.S. Armed Forces by their dedicated service.

I feel it is important for me to point out one area where we did have a slight difference of opinion, on the issue of VA judicial review. However, at my suggestion the approved Senate bill does include a 5-year sunset provision. It is designed to require a thorough congressional evaluation of the operation and effects of the new judicial review provisions before they are made permanent or are further extended. In this way, I believe we can make sure that every American veteran gets complete due process for which he has fought so hard.

Again, I want to welcome all who are here today. I share your concern, Commander Hamilton, and I am very interested in your views.

Thank you, Mr. Chairman.

Chairman CRANSTON. Thank you very much, John.

Now, I'd like to recognize Senator Robert Stafford of Vermont who in former days was the ranking minority Republican member of this committee and rendered very effective service. It is always a pleasure to work with him. A great friend.

Senator STAFFORD. Thank you, very much, Mr. Chairman, for those gracious words. It is a real pleasure to serve under your leadership on this Veterans' Affairs Committee and under the leadership of Alan Simpson. I am pleased to join the other members of this committee in welcoming the leaders and representatives of The American Legion to hear from you and to hear from the national commander concerning your legislative recommendations for the balance of this year and next year. I congratulate you, Mr. National Commander Frank Hamilton, and I want to say that you are my commander as well. I have been a member of the Legion since 1946 when I came home from serving in the Navy in World War II.

I know of your interest and of all members of The American Legion in all matters relating to American veterans, their widows, and their survivors. Your presence here today clearly indicates that you care for those who have served and sacrificed for this country in time of war and peace.

You want this Nation to continue to honor and respect its veterans and to live up to the commitments made, benefits provided, and programs initiated. The years I served on this committee I have looked forward to these annual presentations. I know your views and your judgments are given great and careful consideration in our deliberations and in the results achieved by this committee. Thank you for your help and assistance in serving the needs of the veterans of our great Nation.

Thank you.

Chairman CRANSTON. Thank you very much, Bob.

I would like to state that Senator Richard Stone of Florida asked me to indicate to you that he intended to be here, and wanted to be here, but he had to stay in a closed meeting on intelligence matters and that is why he is not present.

I would like to ask the four Californians who are here, and if there are any others who I am not aware of who are here, would they rise also?

There were two others and I welcome you.

Senator STAFFORD. Mr. Chairman, although outnumbered, could I ask Francis Moriarity, whose base of operations is my hometown, if he would stand?

Chairman CRANSTON. We will now move down to the table at long last. I would like to again welcome and note that Bill Lenker, chairman of the National Veterans Affairs and Rehabilitation Commission, is with us. Also Bob Lyngh, director of that commission, and on the other side of the table, Al Brown, chairman of the legislative commission; Mylio Kraja, director of that commission. We are delighted that you are here.

Now, we'd like to hear from you and learn your recommendations. It is a pleasure for me to welcome my distinguished colleagues from Indiana, Birch Bayh and Dick Lugar. I know Birch has a few words he would like to say on behalf of the national commander and then Dick will introduce him.

Senator Bayh is a very important member of the Appropriations Committee whose help on veterans' matters has been absolutely indispensable for their adequate support from a monetary point of view.

Birch, it is great to have you with us.

TESTIMONY OF HON. BIRCH BAYH, A U.S. SENATOR FROM THE STATE OF INDIANA

Senator BAYH. Mr. Chairman, members of the committee. It is a privilege for me to have a chance just to welcome our new national commander and fellow Hoosier, Frank Hamilton. We are proud of the fact that Indiana has produced another national commander. We are proud, aren't we, Dick, of the fact that the Legion headquarters is in Indiana and for that reason Dick and I can claim all the folks in this room.

Particularly, we are proud of the staff folks who do such a good job at national headquarters. We are also proud of the VA hospital facilities there. And if I could I would like to, on a personal note, also recognize the commander of the Legion Auxiliary, Mrs. Kennedy. The auxiliary plays such an important part in Legion life, as my wife Marvella understood with her Girl's State and Girl's Nation activities. I think both Girl's and Boy's States have done so much to create the sense of value in young Americans over the years and, gratefully, we can never lose sight of that fact.

Also, I think the record should note that The American Legion was one of the organizations to early on determine that it was going to join in our war against cancer that we are determined we are going to win. We are still doing that, Frank, and I want to salute you and the auxiliary for the resources and determination that you brought to this battle.

My distinguished colleague, Senator Lugar, is officially going to introduce our new commander and I think that is appropriate. They have similar partisan political views.

However, I think it is also appropriate to note, as has been rather obvious this morning, that the mission of the Legion and purposes of the Legion to serve America bears no political brand and it has been my real privilege to work with you, Mr. Chairman. You have been out there on the point fighting these battles and I consider it a privilege to have a seat on the Appropriations Committee enabling me to work with you and have a chance to get additional and necessary funding. I just refuse to accept the wisdom of those who feel that as insidious as inflation is and as determined as we all are to get it under control, as concerned as we are about balancing the budget, we are not going to balance the budget on the backs of those who have served their country so faithfully when we were in crisis.

I have already said more than I intended. Having brothers Lyngh and Lenker here reminds us that if there is any group that deserves the investment of our tax dollars it is those veterans that these men and those before them are in the process of trying to rehabilitate. So, I want to pledge to you, and to our new commander, my continued support for those programs that mean so much to all of us as Americans, not just as veterans but as Americans.

Chairman CRANSTON. Thank you very much, Birch.

Now, for purposes of making the introduction that we have all been waiting for, Senator Richard Lugar of Indiana, a good friend of the Legion and all veterans.

TESTIMONY OF HON. RICHARD G. LUGAR, A U.S. SENATOR FROM THE STATE OF INDIANA

Senator LUGAR. Thank you, very much, Mr. Chairman and members of the committee. There is, indeed, a festive atmosphere and an important atmosphere in this room today and I must say that the euphoria in Indiana is still there after months following the election on August 23 at the 61st annual convention of the American Legion.

Another great commander, Frank Hamilton, was elected. As my colleague, Senator Birch Bayh has pointed out, Frank Hamilton is the third commander to come from the State of Indiana, the first two being distinguished former Governors of our State, Paul V. MacNutt, who served in the period of 1928 and 1929 and George N. Cray in 1949 and 1950.

Is this a prediction of what will happen to you, Frank?

The American Legion has been an important aspect of our State's history because of the commanders that not only commanded with regard to the national scene but that they had grassroots support in Indiana and that support remains.

The national headquarters in Indianapolis are the headquarters not only for the Legion but likewise for patriotic affairs throughout our State. The parades are great in Indianapolis and throughout the State of Indiana and they are a manifestation of the way Hoosiers feel about the Legion and about their country.

So, it is appropriate that the new commander, my friend Frank Hamilton was born in Indianapolis on January 6, 1923, and that he attended public schools in Indiana.

He received a bachelor of science from Indiana University and an LL.B. in doctor of jurisprudence from Indiana University Law School. He enlisted in the U.S. Army Reserve in 1942; went on active duty later in 1945 with a commission as second lieutenant. Frank attended infantry school in Fort Benning, Ga., and served with the U.S. army of occupation in Japan.

He was separated from active service in 1946 but held his commission until 1953.

Frank Hamilton has been a practicing attorney in Greensburg, Ind., and an important citizen of that city.

That has not precluded his constant activities in Legion affairs throughout the past quarter century. He has been a member and is a member of the Walch Crowley Kramer Post No. 129 of the American Legion in Greensburg, Ind. He served as commander of his home post in 1959 and 1960. He has served as judge advocate and commander of the 10th district of the Indiana Amercian Legion.

From 1962 to 1963 he served as the judge advocate of The American Legion in Indiana. In 1964 and 1965 he became the Indiana southern vice commander. He was the commander of The American Legion of Indiana in 1966 and 1967 and served on the Indiana American Legion Committee as chairman of the American Commission and The American Legion Leadership Conference.

He has served on the national level as a member of the American Internal Affairs Commission and from 1974 to 1978 was chairman of the National Legislative Commission, resigning that latter post to campaign actively for the position of national commander for which he has received a strong endorsement of his home department of Indiana.

Frank Hamilton has been a wonderful friend over the years as has his son, Frank, Jr. It is not, I hope, a partisan remark to indicate that that is a family that has been vigorous in the political life of our State. As a matter of fact, young Frank ran for Congress, unsuccessfully, but in a very courageous race in Indiana just in the last election. It is a real privilege to have this opportunity to introduce to the committee a man that you have known for many years already and with whom I am certain you will enjoy working during the coming year.

Frank Hamilton, National Commander of The American Legion .

TESTIMONY OF FRANK I. HAMILTON, NATIONAL COMMANDER, THE AMERICAN LEGION, ACCOMPANIED BY WILLIAM LENKER, CHAIRMAN, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION; ALBERT D. BROWN, JR., CHAIRMAN, NATIONAL LEGISLATIVE COMMISSION; ROBERT E. LYNGH, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION; AND MYLIO S. KRAJA, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION

Commander HAMILTON. Thank you, Dick for your very kind introduction and it is really deeply appreciated coming from one Hoosier to another.

Mr. Chairman, members of the committee, I have known Senator Dick Lugar for many years as he indicated. I have always valued his counsel and his friendship. Now, on the other side of me is an old street buddy from Terre Haute, Ind. I will say one thing, his daddy was a real high school basketball referee and he brought Birch up the right way.

Birch, I want to thank you for taking your valuable time to be with us this morning and I certainly appreciate the courtesy that you extended to me before this distinguished committee.

Well, gee, you have seen three Hoosiers sitting together. They want to be excused because they have got to represent the people of Indiana, wherever it may be in this building or across the street. Thank you.

Mr. Chairman, and members of the committee, I would like to be permitted to introduce several guests. In the audience we have with us the president of The American Legion Auxiliary, Mrs. Agnes Kennedy, from the State of New York. Agnes?

Her officers, Mrs. Doris Seymour, national vice president.

National secretary of The American Legion Auxiliary, Mrs. Miriam Junge.

The chairman of the National Legislative Committee, Mrs. Helen Adams.

I also brought a representation of my personal family with me today, my wife, Ethel.

The youngest of our six children, Miss Elizabeth Hamilton.

And the oldest of our six children, Frank, Jr.

And his lovely wife, Suzzane Hamilton.

Her mother who is a resident of this district, Mrs. Dorothy Jackson.

You have heard referrals to Bill Lenker and his division director, Bob Lyngh, on my right. We have that great Texas representative from the Lone Star State, a capable national legislative chairman, Albert P. Brown, Jr., of Texas, and my Buckeye friend, the director, Mylio Kraja.

Mr. Chairman, our statement has been submitted and I respectfully request that it be made a part of the hearing record in its entirety.

Now, before I give my testimony, I would like to acknowledge the efforts of you, Senator Cranston and the members of this committee for your attempt at increasing budgetary levels for fiscal year 1980 for veterans benefits and services by $300 million in authority and $400 million in outlays. The American Legion was bitterly disappointed that the Cranston amendment was tabled by a vote of 49 to 39.

I carefully reviewed the names of those Senators who voted to table the amendment and to be very honest with you I was bewildered. Many of the Senators who voted against the Cranston amendment later voted an increase in defense spending.

Mr. Chairman, no organization is more dedicated to a strong defense posture than The American Legion. If it makes sense to maintain a strong defense posture, then it also makes sense to care for those who did the defending.

Mr. Chairman, the Legionnaires that I am proud to represent are not only biting the bullet, they have dodged real bullets on the battlefield and many, I am sorry to say have caught bullets that will leave them crippled for the rest of their lives.

I believe the time has come to realize that the true cost of war begins after the last shot is fired. I again, applaud your leadership and the leadership of this committee for a gallant attempt to make sure that veterans are not forgotten and I pledge the support of The American Legion to get the moneys needed when the House-Senate conferees meet, hopefully later this week to work out the differences in their respective versions of the budget resolutions.

Now, I would like to highlight my statement, Mr. Chairman.

All of us who are interested in veterans affairs had been concerned in the recent past about the future of the VA medical care program. Officials of the administration, including the President, the VA Administrator and the Chief Medical Director, have repeatedly offered assurances as to the future of that program.

However, at the same time, these officials have presided over the reductions in the system that clearly diminishes its ability to meet the demands for care of eligible beneficiaries. And while these actions have been taken and projected, the administration has continued to assure us that they will do more with less.

But they are not doing more with less, because we are receiving information from American Legion service officers, and from our own field representatives, that veterans are, in fact, being turned away from hospitals and clinics—veterans with non-service-connected disabilities who need care.

We note that as of June 1979, VA was operating 86,790 beds. Twenty years ago, the VA was operating 120,000 beds. This is an elimination of 33,210 beds.

Now, the VA insists it does not need these beds. We are categorically opposed to any more bed losses. The reduction of the size of the system has gone too far. The VA is faced with the inevitable increase in demand for both inpatient and outpatient care.

We know that the demand for care is going to increase and it is essential that VA be able to respond to that demand, which it will not be able to do if it keeps on closing beds.

As we have said earlier, VA is already turning veterans away and that practice will increase if the size of the system continues to be reduced.

We know that the President has recently addressed a letter to Senator Cranston, in which he renewed his pledge to maintain a viable medical care program for veterans. We accept the President's word. However, his assurances are not going to bear fruit as long as the size of the system continues to be reduced—and benefits for needy veterans continue to be curtailed.

If the President wants a positive response from the veteran constituency, he will have to match his words with deeds in the operations of the veterans' medical care program.

Now, the budget proposed for VA by the administration was a straight line budget. Funding was provided for new construction, for projects that has long been planned and approved. In benefits, other than the curtailments that I mentioned earlier, the only change proposed was a modest 7.8-percent increase in compensation and death benefits for the service disabled and the survivors of the service deceased. This is the most deserving category of beneficiaries.

The additional increases signify the intention of Congress to provide for them in the face of a double-digit inflation that they have the full support of The American Legion.

We are further grateful for the additional funds that will be provided for health care and we urge the Congress not to enact the benefit curtailments that the administration has proposed.

The American Legion has more than 700,000 Vietnam-era veterans in its national membership. We have a strong concern for the welfare of all Vietnam-era veterans and we have demonstrated this by support of programs to aid their adjustment.

The American Legion believes there should be an immediate increase in education allowances for those Vietnam veterans who are still in training under the GI Bill. During fiscal year 1978, more than 1.5 million Vietnam veterans continued to receive training under the GI Bill. While it is expected that this number will continue to decline, there still will be a significant number of veterans in education and training programs in the fiscal year 1980.

They urgently need an increase in the education and training allowances which were last increased on October 1, 1977.

Now, there is another problem specifically affecting the Vietnam veteran to which the Government must pay greater attention. That is the residual effect on veterans who were exposed to Agent Orange. There was widespread use of this highly toxic herbicide during the fighting in Vietnam.

Thousands of U.S. servicemen came in contact with it in fighting areas. Now, there is a strange apathy evident by the Government in trying to ascertain what the residual effects may be on the health of those exposed.

The American Legion states categorically that the Government of the United States must accept the consequences of its own actions. It has no right to resolve any doubt in this matter in its own favor. Our most recent national convention took note of this problem in Resolution No. 158 out of the District of Columbia and we intend to take every action necessary to insure that the VA does not drag its feet on this issue. The American Legion has also supported a new veterans death and disability pension program because although it is somewhat more restrictive than the earlier programs, it does accomplish two necessary goals.

It treats all beneficiaries equally and assures the greatest amount of pension for those most in need.

Most new programs are not perfect at their inception. In a period of experience with the new program, the Legion reserves the right to approach the Congress to seek improvements in the new pension program as the need for those become apparent.

Now, on the basis of our mandate from out 1978 national convention, The American Legion has introduced into this Congress H.R. 2057, a measure that would provide a special pension program for veterans of World War I. That mandate was renewed at our 1979 national convention.

Now, The American Legion believed that these veterans should have a special pension program, that is liberal and generous to them in consideration of their special status.

It behooves the Nation now to show them a measure of generosity. The American Legion earnestly petitions that the Congress do just that.

Now, there is a special problem that affects a considerable number of World War II and post-World War II veterans. That is the effects of exposure to ionizing radiation or the consequences of a series of nuclear explosions that took place mainly in the testing of new weapons.

There is, today, a clearly defined attitude of reluctance by a number of Government agencies, including the VA, I am sorry to say, to provide all information available in Government files that will make possible the prompt and fair evaluation of claims.

This attitude by these Government agencies is one unworthy of dismission. Those responsible for the foot dragging should be called to account by this committee.

The hearings that have been held on this subject to date were a good beginning but more needs to be done. Our national convention also addressed this problem in Resolution No. 547. And on the basis of that mandate we intended to pursue this matter vigorously. We hope for the support of this committee in that effort.

One of the legislative proposals of the administration, in the field of veterans' affairs, calls for a reimbursement of the VA benefits due on health insurance policies carried by veterans being treated in VA hospitals for non-service-connected conditions.

The Legion national convention addressed this matter in Resolution No. 456 from Georgia and on the basis of that mandate we shall oppose the concept of third party reimbursement. If third party reimbursement becomes law, we fear for the ability of all of us to defend the veterans' health-care program against the inclusion in a national health insurance law.

The recently concluded convention of The American Legion continued our long-standing mandate against judicial review of veterans' claims. Now we continue to be convinced that veterans and their dependents are receiving a level of consideration of their claims for benefits now under the liberalized policies of the Veterans' Administration that will not continue, including the Federal judiciary becoming involved, creating an adversary relationship between the claimant and the Government and the making of decisions of the adjudicative processes of VA subject to review by Federal judges.

Section 3103(a) of title 38 of the United States Code, as amended by Public Law 95-126, establishes a statutory bar to the receipt of benefits by a serviceperson who is a.w.o.l. for 180 days. The American Legion supported this measure.

The administration has effected the introduction in the Senate of S. 1041 which would eliminate that bar to benefits. It is our view that entitlement to veterans benefits is an inducement to honest and faithful performance of military duty. To relax the standards of qualification for benefits is to put a premium on refusal or failure to perform duty.

To grant benefits to those who do not perform duty is an insult to those who do. We also believe the American people have every intention that veterans benefits be reserved for those who serve best the national interest.

Deserters and chronic a.w.o.l.'s cannot be placed in the same category as those who perform such valuable service. We hope that the Congress will not entertain this administration measure.

The American Legion is most appreciative of the fine support it has received from Congress in legislation to improve employment programs for veterans. We are also aware that many times it would not have been necessary to appeal to the Congress for either legislation or oversight functions if the Department of Labor had implemented legislation promptly and efficiently.

The long and recurring history of the Department of Labor antipathy for veterans programs has convinced us, the American Legion, that an Assistant Secretary of Labor Veterans' Employment is essential to insure the full implementation of all the measures Congress has enacted to provide comprehensive and effective employment services for the Nation's veterans. We fully support S. 250 introduced by Senator Strom Thurmond for this purpose pending before the Committee on Government Affairs.

Now, Mr. Chairman and members of the committee, there are other matters concerning veterans benefits in which The American Legion is interested and that will require legislative action. We shall approach the committee about these in the early months of next year.

Before closing, however, I would like to offer a few final observations. With some of the administration proposals and actions mainly affecting health care programs for veterans and with certain recent expressions in the public press, for example, a recent editorial in the New York Times and an article in U.S. News & World Report, it seems very clear to The American Legion that we are once again beginning to experience the phenomena of peacetime, the grudging of benefits for those deserving veterans. May we point out that in the fiscal year 1975, veterans benefits and services consumed 5.1 percent of the Federal budget.

In fiscal year 1979, they will consume but 3.8 percent. Why then, the charge of being too costly? Between 1960 and 1978, the VA medical programs increased in cost by $4.2 billion; but $3.3 billion of that was inflation. Now, the Congress has faced up to the need for caution in the income supplemental program, through its adoption of Public Law 95-588, which revised the pension program. The VA medical care program, while providing needed care for veterans has benefited the entire American people through its research and education programs.

It is too bad other federally financed health care programs are not as cost efficient and as beneficial as is the veterans' health care program.

We do not think that the complainers represent the true wishes or the intentions of the American people.

For our part, we continue to place our trust in the Congress, which is really the true representative of all the people. We see no sentiment here at this time to compromise on promises, implicit and explicit, that were made to those who were asked to serve the Nation in time of war.

Mr. Chairman and members, The American Legion appreciates the courtesies extended to us at this appearance and we wish to compliment you and your colleagues for your dedication to the care of and benefits for the veterans of our great Nation.

I am well aware that your commitment includes the defense of existing programs and it concerns us that there seems to be an increase of efforts to decrease and eliminate various veterans programs.

The American Legion recognizes this contribution on your part. I wish to also further comment on the relationship that exists with our respective staffs.

The cooperation of your offices with Mr. Steinberg, Mr. Shriver, Mr. Scott, and all those of the staff of the Senate Committee on Veterans' Affairs. I would also like to remind you that you are to be our guest of honor this evening from 5:30 to 7:30 p.m., at the Rayburn House Office Building, rooms B-339 and B—340.

This reception is, indeed in your honor. The American Legion and American Legion Auxiliary are looking forward, along with me, to greeting you this evening.

Thank you.

Mr. Chairman, I made another boo-boo. Did you ever make any boo-boo's before? I forgot to introduce Frank Momsen. It was not in the print so I did not read it.

Chairman **CRANSTON**. Thank you very, very, much commander for a fine statement of your program. We look forward to working with you. There are many matters that are going to be tough but we will be working together.

I appreciate very much your recognition of our efforts and your recognition of the fine quality of our great staff in matching and meshing with your staff. We can do a great deal together. We do look forward to seeing you at the reception this evening. Before we adjourn this hearing I want to recognize Senator Gordon Humphrey of New Hampshire.

Senator **HUMPHREY**. Thank you very much, Mr. Chairman. I understand that my colleague Senator Durkin has already had the pleasure of introducing Keith Fleury and Mike LaRocca. I am glad to see both of them today. I look forward to reviewing your fine testimony, Mr Hamilton. I am scheduled for three hearings and one floor speech simultaneously, so I am a bit pressed for time, but I have my chief aide for veterans matters here.

He has heard the legislative presentation this morning and will be filling me in. Thank you, Mr. Chairman.

Chairman **CRANSTON**. Thank you very much.

Thank you all again. We look forward to seeing you tonight and when we need to be together in our common battles we will be together then.

Thank you very much. This hearing is adjourned.

[Whereupon, at 12:10 p.m., the hearing was adjourned.]

[The prepared statement of Commander Hamilton follows:]

PREPARED STATEMENT OF FRANK I. HAMILTON, NATIONAL COMMANDER
THE AMERICAN LEGION

Thank you, Dick, for your very kind introduction...it was deeply appreciated. Mr. Chairman and Members of the Committee, I have known Senator Dick Lugar for many years and have always valued his counsel and friendship. Before I begin my testimony I would also like to thank Senator Bayh for taking the time to be with us this morning. Birch, I appreciate the courtesy you have extended to me before this distinguished Committee.

Mr. Chairman and Members, permit me to introduce several guests and those at this table.

In the audience are members of my family, my wife Ethel, my daughter Mary and my son Frank, Jr.

I'm also privileged to present the National President of the American Legion Auxiliary, Mrs. Agnes Kennedy of New York and her officers Mrs. Dora Seymour, National Vice President, Mrs. Miriam Junge, National Secretary and Mrs. Helen Adams, Chairman of the National Legislative Committee.

At the witness table with me is Mr. Bill Lenker, Chairman of the National Veterans Affairs and Rehabilitation Commission and his division director Mr. Robert E. Lyngh; also joining me is Mr. Albert D. Brown, Jr., Chairman of the National Legislative

Commission and his division director Mr. Mylio S. Kraja.

Mr. Chairman, our statement has been submitted and I respectfully request that it be made part of the hearing record in its entirety.

I wish now to highlight our statement and in respect of our time limits to then have the opportunity to respond to any questions there may be.

VETERANS MEDICAL CARE PROGRAM

The centerpiece of the veterans benefits program is the medical care program that is operated by the Veterans Administration. The American Legion is keenly aware that without this centerpiece it would be difficult to justify the continuation of the VA as the single agency for the administration of veterans benefits. Which is why the Legion reacts so quickly to perceived danger to the medical care program, and works so hard for the continued improvement of the program.

All of us who are interested in veterans affairs, have been concerned in the recent past, about the future of the VA medical care program. Officials of the Administration, including the President, the VA Administrator and the Chief Medical Director have repeatedly offered assurances as to the future of that program. However, at the same time, these officials have presided over reductions in the system that clearly diminish its ability to meet the demands for care of eligible beneficiaries.

As all of us know, the additional funds that Congress provided in the Fiscal Year 1979 Budget, for the operation of beds, and necessary staff increases, were used instead to fund pay raises for Federal employees. 3200 beds have been closed down, and more than 6,000 personnel have been eliminated from the Department of Medicine and Surgery during this Fiscal Year. The Administration's proposed Budget for FY 1980, was essentially a straight-line budget, and called for a further reduction of DM&S employees - which would very likely lead to more bed closures.

And while these actions have been taken and projected, the Administration has continued to assure us that they will do more with less. But they are not doing more with less, because we are receiving reports from American Legion Service Officers, and from our own Field Representatives, that veterans are in fact being turned away from hospitals and clinics - veterans with nonservice-connected disabilities, who need care.

Congress responded to our expressions of concern, and has provided additional funds in the Appropriations measure for Fiscal Year 1980, to restore 3800 staff members to the Department of Medicine and Surgery. Let me say quickly, that we are grateful for the additional $76.4 million.

But already, we are faced with the same old story. Under date of July 19, 1979, the Deputy Director of OMB addressed a letter to Senator Proxmire, in which the Administration agreed to the funding of 3200 personnel. But it expects to recover these costs by a significant reduction of benefits. In H.R. 3892, an Administration measure, travel allowances, over-the-counter drugs, and dental care for Vietnam Era veterans will be reduced. Please note that the largest number of those who will be affected by these reductions are old and poor veterans. This exchange is not what we would call generous.

The American Legion asks Congress not to offset the gains in needed employees by the reduction of benefits for needy veterans. And as to the curtailment of this dental benefit, there is no valid reasón that we know of, why the one year eligibility for one-time dental care for Vietnam Era veterans should be reduced to six months. Thousands of veterans have already had the advantage of this benefit. Why deny it to those remaining who may be eligible for it?

As to bed closures, we note that as of June 1979, VA was operating 86,790 beds. Twenty years ago, VA was operating 120,000 beds. That is an elimination of more than 33,000 beds. VA insists that it doesn't need these beds. We agree that some losses were dictated by fire and safety regulations, and the need for more personal privacy for patients. But we are categorically opposed to any more bed losses. The reduction of the size of the system has gone far enough. VA is faced with an inevitable increase in demand for both inpatient and outpatient care. This increase will stem from the increase in the size of the veteran population, and from the fact that the average age of the remaining WW I veterans is now in excess of 83 years, and the average age of 12.5 million WW II veterans is now 59.5 years; meaning that these WW II veterans are arriving at the time of life when they will be increasingly subject to the catastrophic illnesses that are associated with advancing years. We know that the demand for care is going to increase, and it is essential that VA be able to respond to that demand; which it will not be able to do if it keeps on closing beds. As we have said earlier, VA is already turning veterans away - and that practice will increase if the size of the system continues to be reduced.

We know that the President has recently addressed a letter to Senator Cranston, in which he renews his pledge to maintain a viable medical care program for veterans. We accept the President's word. However, his assurances are not going to bear fruit as long as the size of the system continues to be reduced, and benefits for needy veterans continue to be curtailed. If the President wants a positive response from the veteran constituency, he will have to match his words with deeds in the operation of the veterans medical care program.

Before completing my remarks on the veterans medical care program, I do want to commend VA for certain things that are being done. The American Legion supported the enactment of Public Law 96-22, The Veterans Health Care Amendments Act of 1979. This measure will strengthen VA's effort to assist Vietnam Era veterans who are having readjustment problems, and it will further strengthen the VA's alcohol and drug treatment programs. The problem of alcoholism, especially, is a serious one among veterans of all ages, and VA is deserving of credit for its efforts to deal with this problem. In addition to the provisions of PL 96-22, VA has instituted a pure research program into the causes and effects of alcoholism, and is now in the process of establishing clinical fellowships in the treatment of alcoholics and drug abusers. The benefits of these efforts will extend to the entire American people.

Similarly, VA is expanding its activities in the field of geriatric medicine and gerontology. With an aging veteran population, and an aging national population, these new and exciting programs are to be highly commended. The American Legion strongly supports them.

VETERANS ADMINISTRATION BUDGET

Discussion of the veterans medical care program leads quite naturally to discussion of the VA Budget for Fiscal Year 1980. And even though budget action has been essentially completed by Congress, some observations are indicated.

In the first place, the Budget proposed for VA by the Administration was a straight-line budget. Funding was provided for new construction, but this was for projects that have long been planned and approved. In benefits, other than the curtailments that I mentioned earlier, the only change proposed was a modest 7.8 percent increase in compensation and death benefits for the service disabled and the survivors of the service deceased. Since these are the most deserving category of beneficiaries the Government has, the additional increases Congress signifies intention to provide, in the face of double digit inflation, are strongly indicated, and they have the full support of The American Legion.

We are further grateful for the additional funds that will be provided for health care, and we urge the Congress not to enact the benefits curtailments the Administration has proposed.

The final figure in the Appropriations measure of nearly $20.3 billion should fund veterans programs with reasonable adequacy. This figure does entail some reduction in personnel in the Department of Veterans Benefits. If these reductions result in a generalized delay in delivery of benefits to eligible veterans and their dependents, the Legion will bring the matter to the attention of this Committee, with a request for any necessary personnel adjustments. Most of those who are in receipt of veterans benefits, of whatever category, have urgent need of such benefits - and unusual delays in delivery, by reason of manpower shortages, are unfair, and to be avoided. We trust the Committee will agree with us on this point.

VIETNAM ERA VETERANS

The American Legion has more than 700,000 Vietnam Era veterans presently enrolled in its ranks. We have a strong concern for the welfare of all Vietnam Era veterans, and we have demonstrated that by support of programs to aid their readjustment.

The President also has repeatedly expressed concern for Vietnam veterans in public statements he has made. We note, however, that his Budget proposal for FY 1980 did not include any specific recommendations for improvement in benefits for this generation of veterans.

The American Legion believes there should be an immediate increase in the education and training allowances for those Vietnam veterans who are still in training under the GI Bill. During FY 1978, more than 1.5 million Vietnam veterans continued to receive training under the GI Bill. While it is expected that this number will continue to decline, there will still be a significant number of veterans in education and training programs in FY 1980. They urgently need an increase in the education and training allowances, which were last increased on October 1, 1977. We realize such an increase will cause a budget problem; but it is important that the Government complete its commitment to these veterans by making it feasible for them to complete their education and training programs; and this can only be done if the allowances are realistic in the face of double digit inflation. The American Legion has called for an increase of 15%, which we do not consider excessive. We will support any reasonable amount that Congress can agree on.

As required by Public Law 95-202, VA has completed a study of the Vocational Rehabilitation Program, Chapter 31 of the United States Code, and on the basis of that study has proposed legislation to revise and improve the program. The American Legion supports the revision as overdue and necessary.

There is another problem, specifically affecting Vietnam veterans, to which the Government must pay greater attention. And that is the residual effect, on veterans who were exposed to it, of Agent Orange. There was widespread use of this highly toxic herbicide during the fighting in Vietnam. Thousands of U.S. servicemen came in contact with it in the fighting areas. Now, there is a strange apathy evident by the Government in trying to ascertain what the residual effects may be on the health of those exposed.

As a result of pressure from Congress, and others in the nation, the VA has now established a professional level study committee, on which the Legion has representation through its Medical Consultant. We will certainly work with VA in completing this study. But time is of the essence. Claims are being filed now by Vietnam veterans who believe they have developed disabilities stemming from Agent Orange exposure. Since the use of this substance was an act of war by our Government, we expect VA to pursue an extremely liberal course in considering these claims. If there is the least possible chance that the herbicide has caused any disease, or disabilities of any kind, the VA should pay these claims. The American Legion states categorically that the Government of the United States must accept the consequences of its own actions. It has no right to resolve any doubt in this matter in its own favor. Our most recent National Convention took note of this problem in Resolution No. 158 (District of Columbia), and we intend to take every action necessary to insure the VA does not drag its feet on this issue.

VETERANS DEATH AND DISABILITY PENSION PROGRAM

When former National Commander John M. Carey, appeared before this Committee last September, Public Law 95-588, the Veterans and Dependents Pension Improvement Act of 1978, was in final stages of preparation, and did in fact become law effective January 1 of this year. It has proved to be controversial with many veterans, in comparison with the former pension program, mainly because it does not have as many exclusions. The American Legion has supported the new program because, although it is somewhat more restrictive than the earlier programs, it does accomplish two necessary goals. It treats all beneficiaries equally, and it assures the greatest amount of pension for those most in need. In doing so it eliminates some of the anomalies that had crept into the older programs in the course of numerous legislative changes.

Most new programs are not perfect at their inception. Pending a period of experience with the new program, the Legion reserves the right to approach the Congress to seek improvements in the new pension program, as the need for these becomes apparent.

We have already ascertained one significant weakness in the new law - the benefits provided to widows and orphans. These are so restrictive as to be inequitable. Our National Convention last month addressed the problem in Resolution No. 433 (Wisconsin). On the basis of that resolution; we will, in January, submit certain legislative proposals to this Committee. Essentially they will seek to increase the benefit level for widows and orphans to 90% of that paid to veterans, and to strengthen income exclusions in such a way that these beneficiaries will be assured a level of income support that will be meaningful.

SPECIAL PENSION PROGRAM FOR WORLD WAR I VETERANS

On the basis of a mandate from our 1978 National Convention, The American Legion had introduced into this Congress H.R. 2057, a measure that would provide a special pension program for veterans of WW I. That mandate was renewed at our 1979 National Convention.

The American Legion believes these veterans should have a special pension program that is liberal and generous to them, in consideration of their special status.

It was the veterans of WW I who sponsored and helped to develop the broad program of benefits that is now available to the nation's veterans. Many of these benefits, including all of the readjustment programs, were not available to the WW I veterans themselves. Yet they selflessly worked for the welfare of their sons and grandsons, who fought in wars that came after theirs.

Today, there are 600,000 of these veterans surviving. Their mortality curve is high - running at about 4,000 per month. Special attention to their special needs is long overdue. Most of their working years were spent in the midst of the Great Depression, and most of them were not able to acquire enough of the material things of life to see them through their later years.

For all of these reasons, it behooves the nation now to show them a measure of generosity. The American Legion earnestly petitions the Congress to do that.

HEALTH EFFECTS OF EXPOSURE TO IONIZING RADIATION

There is a special problem that affects a considerable number of WW II and post-WW II veterans. That is the effects of exposure to ionizing radiation - or the consequences of the series of nuclear explosions that took place, mainly in the testing of new weapons.

Based on the experience of American Legion Service Officers who are assisting veterans with claims based on radiation exposure, we are able to tell you that there is today a prevalent and clearly defined attitude of reluctance by a number of government agencies, including VA, we are sorry to say, to provide all the information available in government files that will make possible the prompt and fair evaluation of these claims. This attitude by these government operatives ill-becomes this nation.

The development of nuclear weapons was a calculated government policy. The American Legion supported this development in the interest of the national defense. Inevitably, many thousands of servicemen were involved. The Legion never expected that the government, having conducted the tests, with attendant exposure of large numbers of servicemen, would then seek to avoid its responsibility for the consequences of its own actions. This is not the American way. Those responsible for this foot-dragging should be called to account by this Committee. The hearings that have been held on this subject to date, were a good beginning. But more needs to be done.

Presently there are significant numbers of former servicemen who have malignancies that may be attributable to exposure to ionizing radiation. Many of their claims have been denied by the VA. Many more are being subjected to lengthy delays. And in many of these cases, the issue is a matter of life and death. The veterans want to get these claims settled before they die, so they will know their survivors will be protected in their entitlement to benefits. The failure of government employees to deal with these matters expeditiously is unjustifiable, and The American Legion protests against it. It isn't only VA. The Defense Department is also involved, as are HEW, NIH, and the NRC. The employees in these agencies who are trying to save the government money at the expense of the government's own victims, should be ashamed of themselves. Our National Convention addressed this problem in Resolution No. 547, and on the basis of that mandate, we intend to pursue this matter vigorously. We hope for the support of this Committee in that effort.

THIRD PARTY REIMBURSEMENT

One of the legislative proposals of the Administration, in the field of veterans affairs, calls for reimbursement to the VA of benefits due on health insurance policies carried by veterans being treated in VA hospitals for nonservice-connected conditions. The Legion's National Convention addressed this matter in Resolution

No. 456 (Georgia), and on the basis of that mandate we shall oppose the concept of third party reimbursement.

The Administration calculates a savings of some $218 million during FY 1980, by reason of third party reimbursement. This isn't going to happen, which makes the proposal non-productive at the outset.

There is a constitutional question involved here, concerning the interference by Federal legislation into contracts entered into by private parties. This constitutional question is going to have to be settled by the courts, and that is not going to happen during FY 1980.

The cost formula to be used in determining benefits to be paid, is also going to result in long negotiations with the health insurance industry, and possible further litigation. So, neither is the matter of cost formulas going to be settled during FY 1980. Thus, any projected recoveries by the government during the next Fiscal Year are totally unrealistic.

But The American Legion is opposed to third party reimbursement on a further, fundamental basis. The grant of medical care to war veterans was formalized in the World War Veterans Act of 1924. At that time it was a benefit, freely given by the American people, through Congress, to care for the service disabled, and beyond them, to all honorably discharged veterans. The benefit was given in recognition of valuable service rendered during wartime.

In the years intervening since 1924, nothing has happened to change that mandate of the people. Rather, it has been enhanced through the years, in the multitude of legislation Congress has adopted, to strengthen and expand the veterans health care program, to the point that it is today, the finest health care delivery program in the nation. This health program denotes a special relationship between the people and the nation's veterans. To change the nature of the program now would destroy that special relationship.

If third party reimbursement were to become law, then veterans would, in fact, be contributing to the cost of their care, which would place the present medical care benefit on an entirely different basis. We of the Legion don't think the American people want that.

Further, we must add, that if third party reimbursement becomes law, we fear for the ability of all of us to defend the veterans health care program against inclusion in a national health insurance law.

JUDICIAL REVIEW

The recently concluded National Convention of The American Legion continued our long-standing mandate against judicial review of veterans claims.

We are aware that a Senate bill has been reported favorably. However, on the basis of continued study of the issue, we continue to be convinced that veterans and their dependents are receiving a level of consideration of their claims for benefits now, under the liberalized policies of the Veterans Administration, that will not continue should the Federal judiciary become involved, creating an adversary relationship between the claimant and the government, and making the decisions of the adjudicative processes of VA subject to review by Federal judges.

ELIMINATION OF 180 DAYS AWOL AS A BAR TO BENEFITS

Section 3103(a) of title 38 of the United States Code, as amended by Public Law 95-126, establishes a statutory bar to the receipt of benefits by a serviceperson who is AWOL for 180 days. The American Legion supported this measure.

The Administration has effected the introduction, in the Senate, of S. 1041, which would eliminate that bar to benefits. The American Legion, meeting last month, adopted Resolution No. 383 (Minnesota), restating the Legion's support of the statutory bar.

It is our view that entitlement to veterans benefits is an inducement to honest and faithful performance of military duty. Entitlement to such benefits is also an acknowledgment by a grateful American people, of such honest and faithful service. To relax the standards of qualification for benefits is to put a premium on refusal or failure to perform duty. To grant benefits to those who do not perform duty is an insult to those who do so.

We believe the American people have every intention that veterans benefits be reserved for those who serve the national interest.

Deserters and chronic AWOLs cannot be placed in the same category as those who perform valuable service.

We hope that Congress will not entertain this Administration measure.

VETERANS EMPLOYMENT

The American Legion is appreciative of the fine support it has received from Congress in legislation to improve employment programs for veterans. We are also aware that many times it would not have been necessary to appeal to Congress for either legislation or oversight functions if the Department of Labor had implemented legislation promptly and effectively.

I will not go into detail about the past record of the Department of Labor in this regard. I do, however, want to thank the members of this Committee for your most recent help, to assure that there will be funds in the 1980 appropriations bill specifically for support personnel in the Veterans Employment Service field staff. To prevent a recurrence of this Department of Labor effort to seriously weaken the veterans employment programs, with the resulting necessity for the Legion to appeal to the friends of veterans in Congress, we are seeking legislation to provide for these positions -- which had been routinely provided by the Department of Labor for more than forty years.

This long and recurring history of Department of Labor antipathy for veterans programs has convinced The American Legion that an

Assistant Secretary of Labor for Veterans Employment is essential to insure the full implementation of all the measures Congress has enacted to provide comprehensive and effective employment services for the nation's veterans. We fully support S. 250 introduced by Senator Strom Thurmond for this purpose and pending before the Committee on Governmental Affairs.

This Committee, in requiring a letter of assurance from the Secretary of Labor that the Deputy Assistant Secretary for Veterans Employment would have access to the Secretary, before confirming the current holder of this position, recognizes that such access and status in the Department is crucial to the success of the veterans employment programs. We do not believe the Secretary's assurance in this regard is sufficient to overcome what we believe is an anti-veteran bias in the Department of Labor. Only an Assistant Secretary will be in a position to effectively overcome the bureaucratic roadblocks and diversions in the Department.

Mr. Chairman, Members of the Committee:

There are other matters concerning veterans benefits in which The American Legion is interested, and that will require legislative action. We shall approach the Committee about these in the early months of next year. The matters I have discussed today are those we consider to be most important at this time.

Before closing, I would like to offer a few final observations. With some of the Administration proposals and actions, mainly affecting health care programs for veterans, and with certain recent expressions in the public press (for example, a recent editorial in the New York Times, and an article in U.S. News and World Report), it seems clear to The American Legion that we are again beginning to experience that phenomenon of peacetime, the grudging of benefits for veterans.

It is being said again that veterans benefit programs are becoming too expensive; that they are costing too much money, in these times of inflation and of the need for fiscal austerity.

May we point out that in Fiscal Year 1975, veterans benefits and services consumed 5.1% of the Federal Budget. In Fiscal Year 1979, they will consume 3.8%. Whence then the charge of being too costly? Between 1960 and 1978, VA medical programs increased in cost by $4.2 billion. But 3.3 billion of that was inflation. Again, on what basis is the charge made? The programs administered by HEW cost the nation in excess of $180 billion per year. The FY 1980 VA Budget will be $20.3 billion. Is this too much? Most of those who receive veterans benefits, including those in VA hospitals, would be public charges in any case, because they are mostly the poor and the aged. Why is it wrong if they receive assistance in the form of veterans benefits, instead of as wards of the Department of HEW?

Congress has faced up to the need for caution in the income supplement program, through its adoption of PL 95-588, which revised and tightened the pension program. The VA medical care program, while providing needed care for veterans, has benefited the entire American people, through its research and education programs. It is too bad other federally financed health care programs are not as cost efficient and as beneficial to the whole people, as is the veterans health care program.

Nothing was said about the future cost of programs in 1942, when14 million men and women were sent off to serve in WW II. Nor was anything said about future costs when 2.5 million men and women were sent to Southeast Asia, to serve in a war they had nothing to do with starting.

The American Legion is distressed that those with short memories now rise up and say that veterans benefits cost too much. Our organization has said since its founding in 1919 that the cost of war only begins when the shooting stops. These costs are the inescapable consequences of national policy. It is hardly becoming of these complainers to raise their voices now that the wars are over and peace has come.

We do not think the complainers represent the wishes, or the intentions of the American people. For our part, we continue to place our trust in the Congress, which is the true representative of all the people. We see no sentiment here, at this time, to compromise on promises, implicit and explicit, that were made to those who were asked to serve the nation in time of war.

Mr. Chairman and Members, The American Legion appreciates the courtesies extended to us at this annual appearance and wish to compliment you and your colleagues for your dedication to the care of and benefits for veterans of our great nation.

I am well aware that your commitment includes the defense of existing programs and it concerns us that there seems to be an increase of efforts to decrease and eliminate various veterans programs. The American Legion recognizes this contribution on your part.

I wish to further comment on the relationship that exists with our respective staffs - the cooperation with your offices and with Messrs. Steinberg, Shriver, Scott and all those of the staff of the Senate Committee on Veterans Affairs.

I further wish to remind you that you are our guests of honor this evening from 5:30 to 7:30 p.m. in rooms B-339 and 340 of the Rayburn House Office Building. This reception is in your honor and the American Legion Auxiliary and Legionnaires here are looking forward along with me in greeting you this evening.

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FY 1980 LEGISLATIVE RECOMMENDATIONS OF VETERANS' ORGANIZATIONS

TUESDAY, FEBRUARY 26, 1980

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 11 a.m., in room 318, Russell Senate Office Building, Hon. Alan Cranston (chairman of the committee) presiding.

Present: Chairman Alan Cranston (presiding) and Senator Jennings Randolph.

OPENING STATEMENT OF HON. ALAN CRANSTON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman CRANSTON. This hearing will please come to order.

I want to welcome each and all of you here this morning for the Disabled American Veterans' presentation of its legislative goals for the 2d session of the 96th Congress.

I am particularly pleased to welcome Paul L. Thompson, National Commander of the Disabled American Veterans.

Before turning to the presentation of your legislative goals and priorities for this session of the Congress, I would like to take a moment to thank both you, Commander Thompson, and Past Commander Billy Hightower, for the truly meaningful assistance that the DAV, under your leadership, provided this committee during the 1st session of the 96th Congress. I also want to extend the committee's gratitude for your past and ever-continuing dedication to serving that most special group of our Nation's veterans—those who became disabled while serving in our Nation's Armed Forces.

In addition, I want to say what a pleasure it is for the committee to have such good rapport and working relationships with Gabby Hartnett, Ron Drach, Rick Heilman, and "Butch" Joeckel of the DAV's Washington staff who provide your organization with such effective ongoing representation.

I share with you 11 years of your history of deep concern for the VA's health-care system. Working together and with others, we made great advances in the 1970s, both in securing badly needed resources and in focusing VA's resources on its No. 1 priority, the service-connected veteran. From 1970 to the present, we have succeeded in having more than 50,000 health care staff added to the VA system.

However, in fiscal year 1979, as a result of various Administration restrictive actions—that were at the time, under existing law, effectively insulated from prompt congressional correction—the VA system suffered personnel reductions and dislocations that seriously threatened its ability to provide quality health care services and maintain the quantity of services provided to eligible veterans.

The Congress responded in three significant ways to repair the damage. First, in the appropriations process, fiscal year 1980 funding was provided for 3,800 health care employees above the Administration's original request in order, for the most part, to restore personnel cuts made in fiscal year 1979 and planned for fiscal year 1980. Chairman Ray Roberts of the House Committee on Veterans' Affairs and I, together with other Members of both Veterans' Affairs committees—with strong help from your organization—led the fight to get those funds appropriated and to assure that the funds were clearly earmarked for health care staffing.

Second, in Public Law 96-151, the Veterans' Health Programs Extension and Improvement Act of 1979, signed into Law on December 20, 1979, we enacted a mandate that the Director of the Office of Management and Budget each year provide the VA with the ceiling and funding for the health care staffing for which the Congress has appropriated funds. This legislation also requires the Director of the Office of Management and Budget to certify to the Congress quarterly that he has complied with this requirement and the Comptroller General to review that certification and tell us whether the Office of Management and Budget has, in fact, complied.

Third, on October 25, 1979, the House and Senate Committees on Veterans' Affairs conducted an unprecedented joint hearing on VA health care, focusing on quality of care and the problems that had been created by administration cuts in staffing in fiscal year 1979. Your testimony, at that time, Commander Thompson, provided the committees with valuable insight into the nature and extent of the problems. Our committee supplemented that hearing with extensive followup and a November 10, 1979, field hearing that Senator Stone chaired, at my request, in Orlando, Fla.

As a result of all three actions, combined with persistent prodding of the executive branch for the swiftest possible action to allocate and use the ceiling and funding, the VA received the full ceiling virtually as soon as the appropriations bill was signed into law and began its hiring efforts immediately. Thus, as of January 31, 1980, the VA had filled 80 percent of the positions, and was working on a priority basis to fill the rest.

However, in the course of the joint hearing and followup, we also learned of other problems hampering the VA's efforts to provide quality health care.

The hearings confirmed the need to provide a permanent special-pay program—replacing the now outdated, stopgap legislation under which the VA has been operating for 5 years—to help overcome the VA's problems in recruiting and retaining quality physicians and dentists. The hearings also pointed out the need to make other legislative changes to help the VA overcome difficulties it is having in hiring and keeping other direct-patient-care personnel, particularly nursing staff. Thus, I will shortly introduce legislation to develop permanent solutions to those VA health care staff recruitment and retention problems, and I look forward to receiving your testimony on these vital issues at the upcoming hearing on this legislation.

With respect to the VA health care budget for fiscal year 1981, I welcome your comments today on the Administration's budget request. They will be very helpful to the committee in formulating our budget and appropriations recommendations for fiscal year 1981. This is a critical year for the VA health care system, and our initial review of the budget shows a need for some substantial improvements. With your insights and suggestions in mind, the committee will consider its budget recommendations on March 6.

Be assured that this committee will act this year to preserve the gains made in the past and make improvements needed now and in the future. You have my word on that. There will be no retreat, no decline.

On another matter of primary concern to service-connected-disabled veterans, I introduced on February 19 legislation to make a comprehensive improvement, expansion, and modernization of the VA's vocational rehabilitation program under chapter 31 of title 38.

It has been 6 years since this committee first called for a comprehensive revision of chapter 31, in light of the great changes that have occurred since 1943 in rehabilitation concepts and in the roles of seriously handicapped individuals in our society. Thus, I am extremely pleased that we are about to move forward with this legislation, with hearings this Thursday and markup scheduled 3 weeks later.

The provision of comprehensive rehabilitation services with the final goals of placing disabled veterans in suitable employment, whenever feasible, and to help those who are the most severely disabled to achieve maximum independence in the functions of daily living, is an area of my deepest personal commitment. The committee and I, therefore, look forward to receiving your testimony on this legislation and working closely with you in the further development of it. We are fully committed to the enactment of this measure.

I also want to assure you of the support of this committee for a realistic cost-of-living increase in the rates of compensation and dependency and indemnity compensation benefits. Doing what's right for the highly deserving individuals receiving these benefits is a top priority for this committee and, with your help, we'll make certain that they are protected from the stampeding inflation that is ravaging so many Americans.

Finally, with respect to your remaining priority goals for service-connected legislation, I am certain that the committee will give each of your proposals thorough consideration. We, thus, also anticipate working closely together with you regarding the compensation program adjustments you are recommending.

We obviously have great challenges ahead of us this year, challenges we cannot possibly meet separately but, together, as always, we shall prevail.

I would now like to call on Senator Jennings Randolph, of West Virginia, an outstanding member of the committee and a great backer of veterans and their causes. Jennings?

Senator **Randolph**. Thank you very much, Mr. Chairman.

I would just like to reiterate, to all of you from my home State of West Virginia, including State Commander Harry Hughes; Adjutant C. W. Schemp, and former State Commander Ralph Hartman, and from the United States of America, the fact that we were elected to public office and have the responsibility, at least in part, for the passage of law, then to carry it out to its fruition by agencies of government.

And we are constantly on the alert to see that what is done on Capitol Hill is not forfeited or changed by any agency of government. And our commitment will not waiver in these legislative actions taken on behalf of our disabled American veterans.

Chairman CRANSTON. Thank you, Senator Randolph.

Before proceeding with the witnesses, I want you to know that we have statements for the record from Senator Strom Thurmond and Senator Robert Stafford. Without objections they will be placed in the hearing record at this point.

[The prepared statements of Senators Thurmond and Stafford follow:]

PREPARED STATEMENT OF HON. STROM THURMOND, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

Mr. Chairman, it is a pleasure to receive testimony from the Disabled American Veterans concerning their 1980 legislative goals and recommendations. I also would like to extend a warm welcome to National Commander Paul Thompson. As a 26-year veteran whose service encompassed World War II, Korea and Vietnam, you certainly enjoy a common denominator with a vast majority of our Nation's 30 million veterans.

It is my opinion that the primary focus of veterans' benefits should be on the care of those who fought and were disabled while in the service of this Nation. These veterans should anticipate adequate compensation for injuries received and treatment thereafter, and a grateful Nation should be willing to provide such compensation and other benefits which will assist the veteran in his readjustment to civilian life. The Senate Committee on Veterans' Affairs recognizes this service and stands ready to assist all veterans in their efforts to live a productive life after service.

As a member of this Committee, I look forward to your yearly recommendations. It is through these recommendations, and those of other veterans' organizations, that I learn of various problems that have arisen in the complex delivery system of health care and other services administered by the Veterans' Administration, and efforts to resolve these problems can be initiated.

I commend each member of the DAV for the services rendered and sacrifices made while serving our country during wartime, and I urge each of you to assist me now, during peacetime, to maintain the integrity of the VA system.

There are several members of the South Carolina Department in the audience today. If George Mitchell and Simon Mikell could stand, and any other South Carolinians, I would like to recognize you at this time.

I appreciate your being here today and commend the Department and Auxiliary for the fine work they are doing for the veterans of South Carolina.

PREPARED STATEMENT OF HON. ROBERT T. STAFFORD, A U.S. SENATOR FROM THE STATE OF VERMONT

Mr. Chairman, it is always a pleasure to welcome the National officers and official representatives of the Disabled American Veterans to their annual presentation of legislative goals. I join all members of the Senate Committee on Veterans' Affairs in a warm welcome to you, National Commander Thompson, and I am looking forward to hearing your statement of legislative priorities for this year and of your concerns for America's veterans, their survivors and dependents.

Those of us who have served on this Committee a number of years are well aware of the excellent work of your organization of disabled veterans in support of fair and just compensation for service-connected disabilities, for the best possible medical treatment for veterans, for improvement of veterans' employment and in meeting the needs of widows, orphans and dependents of veterans. The DAV has been a tower of strength in support of the efforts in behalf of the veterans of this Nation.

Your national officers and your fine staff keep us well informed during the course of each year, of conditions and needs within the VA health-care system. So that our

Committee can better perform its oversight responsibility, your reports are most helpful. It is our desire, and I know it is yours, that a high quality of health care be sustained in the VA hospital system. So we thank you, individually and collectively, for your continuing assistance in meeting our mutual responsibilities toward our veterans who have sacrificed so much for all of us. As in prior years, we will carefully review, consider and act upon the observations and recommendations of the Disabled American Veterans.

Chairman CRANSTON. Now, for purposes of making the introduction, the Chair recognizes the extremely able Senator from Maryland, Paul Sarbanes.

TESTIMONY OF HON. PAUL S. SARBANES, A U.S. SENATOR FROM THE STATE OF MARYLAND

Senator SARBANES. Thank you very much, Mr. Chairman and Senator Randolph. I am pleased to be before the committee.

Mr. Chairman, I believe I would be remiss, before this distinguished assembly, if I were to neglect to commend you and this committee on the role you have played in insuring this Nation's responsibilities to the men and women who have served this country in its time of most dire need.

Chairman CRANSTON. Thank you very much, Paul.

Senator SARBANES. And I can recall, Mr. Chairman, that first major move towards reorganizing the Senate committee structure and the Veterans' Affairs Committee and the totally altruistic manner in which you and the members of this committee set about your task.

It gives me great pleasure to introduce to you Commander Paul Thompson. He and I have been close friends for a long time, and I value his friendship. I have great respect for his judgment and his ability.

He is a resident of Baltimore and a 26-year veteran of the Armed Forces, having enlisted in the U.S. Army in 1939, serving in the South Pacific during World War II. He reenlisted in the Air Force in 1951, served in Korea, later in Vietnam, and left the service due to disability in 1966, after attaining the rank of master sergeant and earning five bronze stars, as well as several other military decorations.

Paul Thompson has long been active in the affairs of the Disabled American Veterans. He was a strong force in the development of the DAV's Vietnam veteran outreach program, which marshalled community resources to help Vietnam-era veterans overcome the delayed anguish and stresses often resulting from combat experiences.

He has been a leader in our community in church and civic affairs. He has served as a member of the Maryland Veterans' Commission. We are proud of that commission in our State. It has done exceedingly good work in complementing and supplementing the Federal programs. And I am pleased that the chairman of that commission, Claude Calligary, is here with us today. I would like to ask him to stand, if he would.

Mr. Chairman, Paul Thompson's entire life has been devoted to the service of his country, for his fellow veterans, and for its citizens. He is an able and effective advocate for the rights of veterans and a deeply committed champion of improved benefits and programs for former servicemen and women. He is a powerful and eloquent spokesman for a cause which I, wholeheartedly, support. I am pleased that he is here before the committee this morning.

I commend him to you. You will rarely hear such words of wisdom and eloquence as you will hear this morning. We are very proud to have him, a Marylander, as the National Commander of the Disabled American Veterans.

Thank you, Mr. Chairman.

Chairman CRANSTON. Commander, we welcome you.

TESTIMONY OF PAUL L. THOMPSON, NATIONAL COMMANDER, DISABLED AMERICAN VETERANS, ACCOMPANIED BY DALE ADAMS, NATIONAL ADJUTANT; NORMAN B. HARTNETT, NATIONAL DIRECTOR OF SERVICES; WILLIAM E. GEARHART, NATIONAL SERVICE DIRECTOR; JOHN F. HEILMAN, NATIONAL LEGISLATIVE DIRECTOR; RONALD W. DRACH, NATIONAL EMPLOYMENT DIRECTOR; MRS. MAURINE PEDEASON, NATIONAL COMMANDER OF DAV AUXILIARY; AND MRS. KIT SEAL, NATIONAL ADJUTANT OF DAV AUXILIARY

Commander THOMPSON. Mr. Chairman, with your consent, I would like to introduce a few of the DAV officers and staff who are here with us today.

With me here at the table are: National Adjutant Dale Adams; our National Director of Services, Gabby Hartnett; Service Director Bill Gearhart; Legislative Director Rick Heilman; Employment Director Ron Drach; National Commander of DAV Auxiliary, Mrs. Maurine Pedeason of Missouri; National Adjutant of DAV Auxiliary, Mrs. Kit Seal.

I would also like to introduce my National Senior Vice Commander, Stan Pealea of Missouri; National First Junior Vice Commander, Sherman E. Roodzant of California; National Second Junior Vice Commander, Edward G. Galian of New York; National Third Junior Vice Commander, Odell W. Vaughn of Florida; National Fourth Junior Vice Commander, Dennis A. Joyner of Pennsylvania; National Chaplain, Rev. Thomas Meersman of Utah; and National Judge Advocate, Boniface R. Maile of Michigan.

I will ask the DAV National Executive Committee to stand and be recognized.

At this point, I would also ask the members of the Legislative Interim Committee to stand and be recognized.

Mr. Chairman, a gentleman very well known to you, former staff director of the House Veteran's Affairs Committee and, I am proud to say, former national commander of the Disabled American Veterans and presently chairman of the DAV's Health Service Research Committee, Oliver E. Meadows.

As you know, Mr. Chairman, it has been incorrectly implied in the national media that the major veterans organizations do not represent the Vietnam-era veteran. I want you to know this is not true of the DAV.

Twenty-five percent of our national membership, almost 140,000, are Vietnam-era veterans. I am very proud of the fact that 251 of our 287 full-time national service officers are disabled veterans of the Vietnam era. And I would just like to ask those members here in the audience who are Vietnam veterans to stand for recognition.

Mr. Chairman and members of the committee, on behalf of the 656,000 members of the Disabled American Veterans and its 78,000 member Ladies' Auxiliary, may I say it is, indeed, a distinct honor and privilege to appear before this committee in presentation of the DAV's 1980 legislative program.

I intend to discuss several specific priority legislative goals that were approved by the delegates to our most recent national convention, but, for the moment, Mr. Chairman, I wish to direct your attention to what I believe to be the paramount issue of importance now facing America's veteran population.

Almost 1 year ago to the day, in his formal presentation submitted to this committee, my immediate predecessor, Billy O. Hightower, spoke of a crisis of, and I quote, "unprecedented proportions," unquote, that he feared was about to engulf our VA hospital system. He spoke of OMB fiscal clampdowns and the withholding of lawfully appropriated VA medical care funds. He cited the existence of personnel cuts and hiring freezes arbitrarily imposed upon VA medical care personnel. Alerting this committee to the adverse impact that such policies were then having upon the quality and extent of VA health care, he stated, and I quote, "Our hospital system in on the verge of a deep, frightening downhill slide," unquote.

Since Commander Hightower's message of last year, the mantle of DAV Leadership has fallen upon my shoulders. My responsibilities as national commander of our great organization dictate that I continue to place before the American people through you, their representatives in the Congress, and accounting of the life-and-death struggle that now confronts our Nation's system of veterans' health-care benefits and service.

Only now I must tell you that VA health care is no longer on the verge of that downhill slide. During the past 12 months, it has slipped over the edge and, if its rate of acceleration has yet to gather full momentum, it is only because the Congress, acting upon the recommendations of this committee and your counterpart in the House, has refused to accept the destructive fiscal mandates of OMB.

Yet, despite this demonstrated unwillingness on the part of the Congress to follow the VA health-care funding recommendations of the administration, those of us in the veterans' community must recognize that our hospital system has been very severely wounded. Reacting in an atmosphere of high inflation and proposition 13 sentiment, the Congress, through its lengthy and complicated budgetary process, has not increased the regressive VA funding proposals of OMB to the degree that is necessary.

This has been most recently underscored with respect to the action taken in the 1980 VA budget. Though some 3,800 health-care personnel were added by the Congress over and above the administration's original request, this gain was more than offset by the actual 1979 calendar year loss of almost 7,000 medical personnel.

Though more pronounced in recent years, progress of this type—one step taken for every two lost—has been occurring for some time. And it has had these predictable results:

First, increasing numbers of veterans, especially needy, non-service-connected veterans, are being limited or deprived of both inpatient and outpatient care. If they are fortunate enough to gain access into the system, many find that medication and followup services are no longer available.

Second, morale of Department of Medicine and Surgery employees, especially those in direct patient care, is dropping in direct proportion to personnel losses suffered. The reputation of being over worked and underpaid has stymied DM&S recruitment and retention efforts leading to the counterproductive practice of employing part-time and foreign-born physicians.

Third, increasing numbers of hospital beds, medical wards and specialized services are being shut down or not brought onto line. New activations, when achieved, are staffed with existing personnel drawn from the already overburdened existing system.

And what does the administration say regarding the charges of an ever deteriorating state of VA health care? As far as we can determine, while conceding that the need to bite the bullet has hit all governmental departments and agencies, we are told that the VA is assuming no more than its fair share of the burden. The administration insists that the quality of care has not suffered, that greater numbers of veterans are being treated with far less resources because advances in medical science now allow for a higher intensity and greater pace of care. Shorter length of stays and greater turnover rates are looked upon with pride by the administration.

Well, Mr. Chairman, while conceding a degree of validity to the claim of efficient, streamlined operations, the DAV has steadfastly held to its own belief in the law of diminishing returns—that is, you just cannot continually reduce your resources in an atmosphere that sees an ever increasing demand being placed upon the system.

Examine, if you will, the following figures relative to the VA inpatient and outpatient care rendered within the last 5 fiscal years.

Fiscal year	Treatment rendered	Difference	Previous year
Inpatient care:			
1975	1,220,107	Up	79,357
1976	1,287,125	Up	67,018
1977	1,322,773	Up	35,648
1978	1,342,164	Up	19,391
1979	1,342,161	Down	3
Outpatient care:			
1975:			
Total	14,629,517	Up	2,429,517
VA	12,595,514	Up	1,829,514
Fee	2,034,003	Up	600,003
1976:			
Total	16,410,252	Up	1,780,735
VA	14,223,206	Up	1,627,692
Fee	2,187,046	Up	153,043

Fiscal year	Treatment rendered	Difference	Previous year
1977:			
Total	16,955,808	Up	545,556
VA	14,675,284	Up	452,078
Fee	2,280,524	Up	93,478
1978:			
Total	17,416,275	Up	460,467
VA	15,069,573	Up	394,289
Fee	2,346,702	Up	66,178
1979:			
Total	17,262,408	Down	153,867
VA	15,053,332	Down	16,241
Fee	2,209,076	Down	137,626

Commander **Thompson**. These are actual figures, Mr. Chairman; not estimates and they were obtained from the VA, itself. Granted, during fiscal years 1975 through 1978, the VA did provide inpatient and outpatient care to increasing numbers of veterans. However, though the demand for care was increasing rapidly during this time, you will note the VA's ability to accommodate that demand was decreasing proportionately.

The key year, of course, is fiscal year 1979. For the first time in the entire history of our modern-day system, the actual number of veterans treated by the VA has declined. Despite the expanded categories of the new eligibles given entitlement through liberalizing legislation, despite the ever increasing medical care needs of our aged World War I and our aging World War II veteran population, in 1979, not only could the VA not keep up with demand, it treated less veterans than it did the year before.

Mr. Chairman, these figures tell the story and clearly refute administration claims of being able to deliver adequate, quality care to our Nation's veteran population. The crunch that we all fear is not around the corner, it is upon us now.

From a graphic and rather grim illustration of the effects that Washington-imposed fiscal restraints are having on VA field personnel, consider a recent VA Inspector General's finding that revealed one medical facility had instituted the practice of removing pacemaker implant devices from deceased veterans and implanting them into living patients. Upon being informed of this practice, the then Chief Medical Director condemned the policy, conceding that though the cost containment aspect was desirable, the potential negative public relations impact could have a deleterious effect upon patient morale and the doctor-patient relationship.

We find it reprehensible that dedicated VA medical personnel find themselves to be so financially pressed that they must resort to lengths such as this in order to serve their veteran patients.

One might expect this crisis to be addressed by the administration in its fiscal year 1981 budget request. Let me briefly comment upon that request as it relates to the VA health-care system.

Medical care expenditures, after adjustment for inflation, are down at least 5 percent, some $300 million shy of even approaching fiscal year 1980 levels. Yet, after adjustment for inflation, all other Federal health care expenditures are up 1.5 percent.

The VA expects virtually no increase in the number of inpatient treatment rendered and only an infinitesimal increase in the number of outpatient services granted. Fee base outpatient care is expected to be down by some 71,000 treatments.

Despite the huge losses of medical care personnel that occurred in calendar year 1979, the addition of only 50 employees is proposed for DM&S. Reactivations and new facilities are proposed to be staffed by 311 personnel from existing programs.

Inadequate staffing is proposed for the VA's Vietnam veterans' psychological and readjustment counseling program with no personnel for the recently authorized service-connected preventive health care program.

There are proposed cutbacks in the programs of education and training for health care personnel and cutback in funding of over-the-counter drugs and medications.

The VA proposes to eliminate another 1,600 operating beds from the system, absorb 20 percent of the recent Federal pay raise from existing health care funds and save over $260 million, based on the unlikely assumption that Congress will pass benefit reduction and third-party reimbursement legislation.

Clearly, rather than trying to remedy the critical situation confronting the VA health care, or at least making an attempt to hold the line, the administration appears determined to speed the present system on to its demise.

At a time when our hospital system is in need of the strongest advocacy, we see nothing of the sort emanating from the administration. Nor, I regret to say, have we seen any concrete evidence of aggressive leadership on the part of the agency's administrator. On the contrary, what we do see is a series of vague, conflicting signals in the form of rhetoric, adverse fiscal policies, and negative legislative proposals.

The administration states that it favors the independent status of VA health care, yet its own National Health Care Plan Act would subject the system to the influence of HEW.

The administration claims that cost containment of health care expenditures is a nationwide objective, yet, through its own design, thousands upon thousands of eligible veterans are being shunted away from the system, encouraged to seek medical care in the private sector where it is 15 percent more expensive.

The administration claims that it recognizes the VA system as a valuable national resource, leader in medical research and trainer of fully two-thirds of America's graduating physicians. Yet it allows the fate of the system to rest within the hands of OMB officials who apparently regard VA health care as an expendable item.

Mr. Chairman, whether the ills of the VA medical care system are caused through intent or through an incredible shortsighted lack of leadership on the part of the administration and the agency itself, we feel it imperative that the Congress recognize that our VA system is in deep trouble, that there is and has been an absence of nationally stated policy concerning the objectives, level of operations and level of budgetary support for VA medical care.

As it is the Veterans' Affairs Committees who are charged with oversight responsibility toward VA health care, it falls upon your shoulders to convince the Congress to do what it must do—assume the VA leadership role that has been abdicated by the executive branch of our Government.

And, so, my plea to you this day is that you continue unabated in your efforts to preserve, protect and enhance our system of VA health care.

And here, Mr. Chairman, let me add parenthetically a few words that are for this committee alone. Without demeaning in any way the efforts of any others in the Congress, I can state that the DAV regards you, the members of this committee and your most excellent staff as being first among those who are committed to the defense of our VA health care system. For this you have the profound thanks and appreciation of the Disabled American Veterans.

And, now, with your permission, I would like to devote the remainder of my statement to several priority DAV legislative objectives that, we believe, are deserving of the committee's attention.

Disability compensation and DIC increase: Mr. Chairman, it is a fact that this committee has been steadfast in assuring that VA service-connected disability and death compensation benefits are periodically adjusted in order to offset inflationary pressures. The most recent disability compensation increase granted by the Congress in 1979 represents the sixth such increase in as many years.

We in the DAV are indeed grateful for these efforts, as no one is more acutely aware of the ravages of inflation than disabled veterans and widows who depend upon their compensation and DIC benefits to provide the essentials of food, clothing, and shelter.

Unfortunately, 1980 appears to offer no respite from the continual rise in the cost of living. It is not speculative to estimate that we shall have seen the cost of goods and services in this country increase by a figure well into a double digit inflationary rate by the end of this year. Noting that President Carter has included among his legislative proposals a 13 percent cost-of-living adjustment in service-connected disability compensation and DIC benefits, we urge the committee to give a No. 1 priority status to the consideration of such legislation in this session of Congress.

Increased compensation payments for the service-connected loss or loss of use of both upper extremities: Mr. Chairman, in discussion of our next objective, may I first say that the DAV is deeply appreciative of the special effort you have made in meeting the needs of wartime veterans who fall within the most seriously disabled categories. Your acceptance in 1979 of the DAV recommendation that a small group of severely disabled veterans be given authorization for aid and attendance consideration is a most recent example of your concern.

Our 1979 National Convention has again identified a small number of disabled veterans who, we believe, are deserving of a higher rate of compensation payments. We propose an upward adjustment in the compensation benefits of veterans who have incurred the service-connected loss or loss of use of both upper extremities.

According to the VA, there are approximately 125 veterans presently so rated. Depending upon the degree of impairment and/or site of extremity amputations involved, they are rated in the upper special statutory award categories under section 314, title 38, United State Code.

Without going into great detail, Mr. Chairman, let me just point out that, under current law and rating policy, a certain distinction is made—and a higher rate of compensation is paid—with respect to single upper extremity losses. That is to say, the loss of a major arm or hand is recognized as causing a greater impairment than a minor hand loss. These higher ratings and payments are not reflected in single lower extremity losses, as there is no comparable dexterity function involved.

However, when considering bilateral upper and lower extremity losses, this distinction is not carried through and both classes of double amputees are treated the same. We believe this is a disparity that should be rectified.

We also believe that, upon close examination of the loss of function suffered by bilateral arm amputees and the limited extent of function restored by their prosthetic devices, the committee will agree with our objective.

Our proposal would advance these veterans one full step in their present statutory award category, amounting to an average increase per veteran of some $200 per month. The total first-year cost of our proposal is a relatively modest $300,000.

VA automobile and adaptive equipment award liberalization: Mr. Chairman, under current law, an automobile and adaptive equipment award is made available to disabled veterans who have incurred the service-connected loss or loss of use of one or both feet or hands or blindness in both eyes to a prescribed degree. This award consists of (1) a one-time grant, presently $3,800, toward the purchase of a motor vehicle and (2) VA reimbursement of appropriate maintenance and replacement expenses for required adaptive equipment of subsequently purchased automobiles.

Service-connected veterans who have not actually suffered an amputation, but who have incurred serious injury resulting in loss of use of an extremity, do qualify for the award. However, there do exist certain types of disabilities, mainly orthopedic in nature, wherein a veteran can be precluded from operating a motor vehicle that has not been modified and, yet, not have entitlement for the automobile award under current law.

For example, service-connected veterans whose knees or hips are ankylosed at favorable angles do not meet the VA's criteria for a loss of use determination. These veterans, therefore, cannot qualify for the automobile award. Yet, they very definitely may require special adaptive equipment before they can safely operate their motor vehicles.

We propose a liberalization of law that would authorize the adaptive equipment portion of the award—exclusive of the one-time grant—to service-connected veterans whose disabilities are of such a nature that they are required by the motor vehicle licensing laws of their States to obtain certain adaptive equipment.

As State motor vehicle licensing requirements are not uniform, and as the universe of disabled veterans who may possess potential eligibility is not known, we cannot provide a precise cost estimate. However, we can state that the number of eligible veterans would be relatively small.

For example, only 1,800 veterans of all periods of service fall within the ankylosed knee and hip categories described above. Considering this, together with information we do have relative to the frequency of use and the average cost of adaptive equipment purchased by present eligibles, we believe the sum of $2 million to be a reasonable first-year estimate. Future costs, of course, would be relatively insignificant.

VA home modification assistance based upon service-connected blindness or bilateral loss of upper extremities: Mr. Chairman, again in keeping with our desire to promote justified and reasonable liberalization of law, we propose the extension of VA home modification assistance to two categories of severely disabled, service-connected veterans.

Current law provides a program of specially adapted housing assistance for service-connected veterans who have suffered (1) the loss or loss of use of both lower extremities, or (2) the loss or loss of use of one lower extremity together with certain other serious disabilities which severely restrict their ability to ambulate without the assistance of wheelchairs or other prosthetic devices.

Under this program, a direct VA grant not to exceed $30,000, is extended toward the purchase or remodeling of suitable housing. As this program is directed at the totally disabled service-connected veteran who has suffered, wholly or partially, a lower extremity loss of function, the modifications and alterations authorized consist of those which allow for free access, egress, and mobility within the home.

A proposal of our national convention delegates would create a similar, but more modest, form of housing assistance for service-connected veterans who have suffered (1) the loss or loss of use of both upper extremities, or (2) bilateral blindness.

Mr. Chairman, I am sure that we can all perceive, though not fully, that a veteran who has suffered the loss of both arms or the sight in both eyes is extremely limited in his ability to function and live in a normal home environment.

The unique needs of such disabled veterans have been evaluated by my Washington staff, through review of VA examination records and personal interviews with bilateral arm amputees and blinded veterans. Based upon this review, we recommend the creation of a grant, not to exceed $5,000, to enable such catastrophically disabled veterans to obtain proper and necessary home modifications and alterations.

As previously mentioned, there are approximately 125 veterans on VA compensation rolls who have suffered the complete and permanent loss or loss of use of both upper extremities. VA data indicates that some 3,100 veterans are receiving benefits due to service-connected bilateral blindness. Assuming that applications would be received from 10 percent of those eligible during the first year, our proposal carries a modest first-year cost of approximately $1.6 million.

I would point out that our proposal has already been given serious examination by responsible authorities. The Veterans' Administration, itself, supports the extension of housing assistance to the upper extremity category of veteran and the VA has recently completed a study concerning the home modification needs of blinded veterans. We urge the committee's support of this meritorious goal.

Changing the effective date for a reduction in VA benefits: Mr. Chairman, under current statute, when the benefits of a service-connected veteran are reduced or discontinued by virtue of a change in law, administrative issue or physical condition, such reduction or discontinuance shall go into effect on the last day of the month following 60 days after the veteran has been so notified.

The purpose of this 60-day delay is to grant the veteran some small respite from an otherwise immediate reduction in income. It is also intended to provide a period of time in which the veteran, before the actual loss of benefits takes place, can attempt to refute the adverse VA finding.

In the past, 60 days may have been an adequate length of time in which a veteran could gather evidence to rebut an adverse VA decision, submit such evidence and receive reconsideration by a local rating board authority.

However, this is certainly not true today.

In the last 3 fiscal years, the average processing time for a reopened claim has been more than 60 days in 48 percent of all cases and more than 90 days in 32 percent of all cases. The average length of time an adverse benefit decision has remained at the local regional office, after having been formally appealed by the veteran and before being sent to the Board of Veterans' Appeals, has been 190.4 calendar days—some 6 months. Action at the Board of Veterans' Appeals, itself, will add another 3½ months to this appellate process time frame.

Though the veteran may ultimately win his claim at the local level or at the BVA and receive retroactive payments for the moneys withheld, in the interim, he and his family have undergone substantial financial deprivation.

We propose that the law be changed to allow a 120-day period from notification to the veteran before a reduction or discontinuance of benefits would be put into effect. Though relevant claims reduction data is not currently available, we believe the increased Federal expenditures required by our proposal would be relatively minimal.

Mr. Chairman, time does not permit me to fully discuss all of the objectives contained in our 1980 legislative program. However, I would refer you to the contents of our 1980 legislative resolution book that has been previously made available to you and your committee staff. I believe that you will find the majority of our objectives to be reasonable and justified, aimed at improving the condition of those most deserving and in need, the seriously disabled, wartime veteran.

Mr. Chairman, before I conclude my remarks, and though I have already discussed at some length the crisis now confronting the VA health care, I would like to make this one final point.

International turmoil, combined with blatant Soviet aggression have imperiled vital American interests in the Mid-East. Resultingly, discussion of Salt II and detente have been replaced by calls for increased defense spending and resumption of the draft. Military preparedness is now the watchword in our country.

Yet, nowhere in the ongoing debate of what is necessary for America's national security and survival have I heard one reference made to our system of VA health care. And, here, let me underscore that, aside from the much smaller and less prepared system of the military, the Veterans' Administration stands alone as the only major source of Federal medical care anywhere near capable of responding to a national emergency or wartime situation.

I submit to this committee that our VA hospital system cannot, must not, be ignored when considering the quality of our country's national defense posture. I urge you to impress this fact upon your colleagues in the Congress.

This completes my formal presentation, Mr. Chairman. I look forward to working with your committee and its excellent staff in the months ahead as, together, we seek to serve the best interests of our Nation's war disabled, their dependents and survivors.

Thank you very much for giving me this opportunity to appear here today.

Chairman CRANSTON. Thank you very much, Commander Thompson. That was a very forceful and thorough statement.

Again, we look forward to working very closely with you and your fine Washington staff as we explore what we can do in regard to the many issues that you brought up.

Let me stress, again, that in regard to VA hospitals there will be no retreat; there will be no decline. We will stick to that commitment, and I am confident we can fulfill it.

Senator RANDOLPH. That's right.

Chairman CRANSTON. Senator Randolph, do you have a comment?

Senator RANDOLPH. Just this comment. I am glad, Mr. Chairman, that you have made the commitment to restate our position with reference to the VA hospital medical care program.

It has been my privilege and responsibility to be a member of this committee since its inception and to speak out on the issues you have mentioned. You wouldn't, naturally, hear it in Maryland, but up in the hills and valleys of West Virginia, I've been talking about the problems of our veterans and the need to continue our commitment to them.

I'm not going to discuss national health insurance or plans of any Senator or the administration, at this moment, except to say that those plans, whatever they may be, from whatever sources they come, we must not try to do away with the Veterans' Administration program to bring in a new program of any type in national health insurance in this country.

I have just one further comment, Mr. Chairman.

You have approximately 140,000, I believe you said, members of your organization, is that correct?

Commander THOMPSON. That is Vietnam veterans; 140,000.

Senator RANDOLPH. Yes. I meant to say that. Vietnam veterans. How many veterans are there from the Vietnam conflict?

Commander THOMPSON. 2.8 million.

Senator RANDOLPH. What is your estimate——

Commander **Thompson**. Excuse me. We have about 500,000 service-connected Vietnam veterans, overall. And we have about 140,000 of them that belong to our organization.

Senator **Randolph**. I don't want to speak on behalf of an organization, as such, but I am thankful that there are always these organizations, like the DAV which not only are doing a job for your members—and you wish to have a larger membership, understandably.

But what you are doing helps thousands and thousands of others who are not actually members of the DAV. I commend you for that effort.

Chairman **Cranston**. Thank you, Jennings.

I want to read into the record a communication from Senator Stone, a member of this committee, from Florida:

> DEAR MR. CHAIRMAN: I regret that I am unable to attend this morning's meeting of the Committee to hear the legislative presentation of the Disabled American Veterans. I was detained in a closed session of the Foreign Relations Committee concerning the Soviet stake in the Persian Gulf.
>
> I wish that you would convey my regrets to Commander Thompson and the other members of the DAV. I have reviewed their legislative goals for 1980, and want them to know that their goals are my goals.
>
> I look forward to working with them during the session of Congress toward these objectives.
>
> Most cordially,
>
> DICK STONE.

Also, Senator Gordon Humphrey of New Hampshire asked me to greet you for him. He tells me that there is a primary going on up in New Hampshire today which prevented him from personally reviewing your legislative presentation. You can be sure that he will study your proposals very carefully.

That completes our hearing. I thank you, Commander. I thank each and all of you for your presence.

We stand adjourned.

[Whereupon, at 12:10 p.m., the committee was adjourned, subject to the call of the Chair.]

FY 1980 LEGISLATIVE RECOMMENDATIONS OF VETERANS' ORGANIZATIONS

TUESDAY, MARCH 4, 1980

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 11:30 a.m., in room 318, Russell Senate Office Building, Hon. Alan Cranston (chairman of the committee) presiding.

Present: Chairman Alan Cranston (presiding), Senators Herman E. Talmadge, Alan K. Simpson, Robert T. Stafford, Gordon J. Humphrey, Spark M. Matsunaga, and Richard (Dick) Stone.

OPENING STATEMENT OF HON. ALAN CRANSTON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman CRANSTON. This hearing will please come to order. I want to welcome each and all of you here this morning for the Veterans of Foreign Wars presentation of its priority legislative program for the 2d session of the 96th Congress.

I am particularly pleased to welcome your commander in chief, Howard E. Vander Clute, Jr., my able colleague from New Jersey, Senator Bradley, who will introduce the commander in chief, and past commander in chief and chairman of your National Legislative Committee, Ted Connell.

Before turning to the presentation of your legislative goals and priorities for this session of the Congress, I would like to take a moment to thank both you, Howie, and past Commander in Chief Eric Sandstrom for the truly meaningful assistance that the VFW, under your leadership provided this committee during the 1st session of the 96th Congress.

I also want to extend the committee's gratitude for your past and ever-continuing dedication, on behalf of the more than 2.5 million men and women of the Veterans of Foreign Wars and the ladies auxiliary, in honoring the Nation's commitments to its veterans of wartime service.

In addition, I want to say what a pleasure it is for the committee to have such good rapport and working relationship with Cooper Holt, Don Schwab, Al Poteet, Phil Mayo, and the entire Washington staff who provide your organization with such effective ongoing representation.

As you know, I had the privilege of addressing your National Legislative Committee on Sunday. I very much appreciated the warm reception that you gave me on that occasion.

Rather than repeat my remarks at this time, I have had copies made available for you and I will insert those remarks in the record of this hearing at this point.

[Chairman Cranston's remarks before the VFW's National Legislative Committee follow:]

ADDRESS OF HON. ALAN CRANSTON, CHAIRMAN, COMMITTEE ON VETERANS' AFFAIRS, AT THE VETERANS OF FOREIGN WARS NATIONAL LEGISLATIVE COMMITTEE—MARCH 2, 1980

It is indeed a pleasure to be with you today.

I'm grateful for this opportunity to work with your national officers, your legislative policymakers, and staff to achieve a successful national legislative committee meeting.

To each and all of you I extend warm greetings from all the members of the Senate Veterans' Affairs Committee. We are looking forward to our Committee's hearing on Tuesday when you will present your legislative program and priorities for 1980. I also want to take this opportunity to say how pleased I am that the Committee has such a good rapport with your Washington office staff—Cooper Holt, Don Schwab, and others—and your Commander in Chief, Howard Vander Clute, and National Legislative Committee Chairman, Ted Connell. They do a most effective job representing you.

You are all to be congratulated on a job well done in fulfilling your commitment to safeguard the rights of our Nation's veterans.

I am also particularly pleased to share the podium of this great organization with the Chairman of the House Committee on Veterans' Affairs, the Honorable Ray Roberts.

My relationship with Ray Roberts has been as effective as my relationship was with our most highly honored and very dear friend Tiger Teague. Ray Roberts' announcement of his retirement at the end of this Congress comes as a blow to all veterans and a real, personal loss to me. But, he has our deepest gratitude and I know he wants us to carry on the excellent cooperative relationship between the House and Senate Committees on Veterans' Affairs.

You have my pledge today to do everything in my power to see that we do. What's right and fair for veterans has never been a divisive matter; it has never been a partisan matter; and it's never been a cause for contention between the two Houses of Congress. We are all in this effort as equal partners.

We all know that the Veterans of Foreign Wars is a fighting organization. You have fought in the past to protect this Nation from its enemies. You are fighting now to keep the Nation strong and to defend America's honorable commitments to those who have borne the battle, to their families, and to their survivors.

I long ago enlisted in this cause. And I am telling you today that we are going to win. I also want to tell you today that there has never been a more clear connection between the strength of our defenses and the way we treat the veterans of this Nation's wars.

VETERANS' BENEFITS IN THE 95TH AND 96TH CONGRESSES

As we meet today, we are past the halfway mark in the 96th Congress. The first session of this Congress was a good year for the 30 million veterans of this Nation—a good year made better by the vigorous and effective participation of the Veterans of Foreign Wars.

In the past year, and in the preceding Congress—the 95th—your organization has worked together with the Senate Committee and with the House Committee so ably led by my good friend, Ray Roberts. Together we have accomplished many things. We have helped disabled veterans and their surviving spouses and children by providing three consecutive cost-of-living increases for VA compensation beneficiaries—a 9.9-percent increase for the current fiscal year, and we also have expanded and improved both the disability compensation program and dependency and indemnity compensation program. We have improved the Veterans' Administration pension program for veterans and their survivors. Working together, we have expanded education benefits, housing assistance, and burial payments for veterans and their survivors.

In this session, the Senate has passed major GI Bill legislation, including provisions to extend eligibility for certain educationally disadvantaged and unemployed veterans and to provide for a 15-percent cost-of-living increase this year for veterans using the GI Bill to get an education or job training. For both of those provisions, I had your active support, and for that I am very grateful. You were the only major veterans organization to support the targeted delimiting date extension, and your strong support was indispensable to our success.

Yes, the list of our cooperative accomplishments is long and also relates to the VA hospital system, which I will discuss in a few minutes. But, first, I want to mention one more accomplishment specifically because I sincerely believe that it represents a major milestone of great importance to veterans.

This past year the Senate passed landmark legislation to give veterans the right to seek court review of claims for benefits when the VA decides a case against a veteran.

Right now, as you know, the VA is virtually alone among Federal agencies in that its rulings on claims for benefits are immune from review in a court of law.

The VFW knows that such things as compensation and pension benefits, education assistance, and VA medical care are matters of fundamental justice to veterans.

Your organization knows that the absence of judicial review in the VA is basically unfair to veterans. Last year the VFW again stood tall among major veterans' organizations by backing our efforts in the Senate to pass the Veterans' Administration Adjudication Procedure and Judicial Review Act, S. 330.

With your considerable help, that bill passed the Senate. I am hopeful that the House will give this important bill favorable consideration.

VA HEALTH-CARE STAFFING

I now want to turn to another matter of urgent importance to all of us—VA medical care.

The effective teamwork that Ray Roberts and I enjoy with the VFW and the other veterans' organizations was center stage last October when we joined forces to investigate the current status of the veterans' health-care system.

We set out together to probe allegations that the VA is not fulfilling its responsibility to provide prompt and efficient medical treatment to eligible veterans.

We wanted to air charges that fiscal cuts and personnel ceiling reductions—forced on the VA by the Office of Management and Budget—were undermining the effectiveness of the VA medical-care system.

We were especially interested in exploring complaints that some veterans face long delays in receiving treatment and in some cases have been turned away from VA facilities.

Sitting as a joint Committee, Senators and Members of the House heard from a wide range of witnesses on this all-important issue. Your National Commander in Chief, Howard Vander Clute, gave us especially forceful and eye-opening testimony.

To address the problems raised at that hearing, we set in motion corrective actions for the problems that beset the system.

First, in the appropriations process, fiscal year 1980 funding was provided for 3,800 health-care employees above the Administration's original request. This was necessary to help restore personnel cuts that were made in 1979 and planned for fiscal year 1980.

Ray Roberts and I, together with other members of both Veterans' Affairs Committees—with strong help from the VFW—led the fight in Congress to get those funds appropriated and to assure that the funds were clearly earmarked for health-care staffing.

Next, we won a major battle to guarantee, by law, that funds for VA medical personnel positions will never again be waylaid and diverted and spent for other purposes, as they have in the past.

With your help, Public Law 96-151, the Veterans' Health Programs Extension and Improvement Act of 1979, was signed into law by President Carter last December 20.

One part of this new law requires the Director of the Office of Management and Budget each year to provide the VA with the personnel positions and funding for the health-care staffing for which the Congress has appropriated funds.

This new law also mandates the Director of OMB to certify to the Congress quarterly that he has complied with this requirement and the Comptroller General must review that certification and tell us whether OMB has in fact complied.

Because of these actions, combined with our persistent prodding of the executive branch for the swiftest possible action to allocate and use the staff positions that Congress authorized, the VA received full health-care personnel authority virtually as soon as the appropriations bill was signed into law so it could begin its hiring efforts immediately. As of a month ago, the VA had filled 80 percent of the new positions, and it is working on a priority basis to fill the rest.

In the course of the joint hearings and followup, we also learned of other problems hampering the VA's efforts to provide quality health care.

The October hearings confirmed the need to provide a permanent special pay program—replacing the now out-dated, stop-gap legislation under which the VA has been operating for 5 years.

This is needed to help the VA in recruiting and retaining quality physicians and dentists.

The hearings also pointed out the need to make other legislative changes to help the VA overcome difficulties it is having in hiring and keeping other direct patient-care personnel, particularly nursing staff.

I will soon introduce legislation to develop permanent solutions to those VA health-care staff recruitment and retention problems.

I look forward to support from the VFW in enacting a permanent special pay measure to improve care for eligible veterans. I know I will have that support. This is a major problem that must be remedied.

VA REHABILITATION PROGRAM FOR SERVICE-CONNECTED DISABLED VETERANS

A few weeks ago I introduced legislation to make comprehensive improvement, expansion, and modernization of the VA's rehabilitation programs for service-connected disabled veterans. The basic structure of the VA's current vocational rehabilitation program was established in 1943.

In light of the great changes that have occurred since 1943 in rehabilitation concepts and in the roles of seriously handicapped individuals in our society, I am extremely pleased that we are moving forward with this legislation.

The Committee will markup this legislation later this month. Ray Roberts and I are both committed to enacting this year the best possible legislation that we can design in this important area. At the hearing on my legislation last Thursday, the VFW voiced its strong support for it. I thank you for that.

The Veterans of Foreign Wars can be assured that, on all issues involving veterans benefits and services, the Senate Committee will act this year to preserve the gains made in the past and to make improvements needed now and in the future.

You have my word on that. There must be no retreat in the service to veterans, no decline.

VA INDEPENDENCE IN NATIONAL HEALTH PLAN LEGISLATION

This brings me to a matter that I know lies at the heart of our shared concern for the independence and vitality of a separate system of health care and medical services for veterans.

There is a bill pending in the Senate—a proposed National Health Plan Act, S. 1812—that poses a serious threat to VA health-care programs and services.

Included in this otherwise worthy bill—proposed by the President—is a provision that would classify the VA as a provider of health-care services in the national health plan to receive reimbursements through the Secretary of Health, Education, and Welfare for the non-service-connected care that the VA would render.

I want to share with you a firm determination I have reached only this week and which I am going to communicate to the President and the bill's chief sponsor, Senator Ribicoff, about this provision: I will oppose totally any such reimbursement provision, whether in this bill or any other.

This approach is a bad one, and I intended to assure that it is stopped, right here, before that bill is considered further.

If such a reimbursement policy is adopted, it could radically alter the present pattern of VA health care. It threatens to make the VA less patient-oriented. Moreover, to monitor exchanges of money between HEW and the VA, enormous additions to the bureaucracy would be needed—a veritable army of auditors, attorneys, and billing clerks.

Worst of all, I believe this scheme would seriously undermine the VA's ability to provide quality health-care services to eligible veterans. I believe it would bring on a sharp decline in the VA health-care system.

So, be assured that I am utterly opposed to this attempt to commingle funds between the Veterans' Administration and HEW when it comes to providing health care for any veterans—whether service-connected or not.

I will urge Senator Ribicoff, the sponsor of S. 1812, to remove from that bill those provisions that would include the VA in a national health plan and to substitute a provision making clear that the VA is to remain dependent on funds appropriated by the Congress—not on funds provided through health insurance policies.

I will stress to Senator Ribicoff—and also to Senator Russell Long, Chairman of the Finance Committee, and to Senator Herman Talmadge, its Health Subcommittee Chairman and a member of our Veterans' Affairs Committee—that the effect of these provisions would be to require the VA to plan its health-care programs on the basis of retrospective reimbursement.

In other words, the VA—after providing care to a veteran—would have to go seeking reimbursement for costs through another agency whose priorities are other than to assure that the health-care needs of our Nation's veterans are met.

I will point out the insurmountable difficulties that this would create for the VA's ability to plan adequately for the provision of care in its 172 hospitals and hundreds of other health-care facilities. I will point out how it would jeopardize the VA's own successful cost-containment efforts.

Thus, I have determined that national health insurance legislation must explicitly protect the ability of the VA health-care system to provide quality health care to our Nation's veterans.

My goal and yours must be to assure that the VA health-care system will not be integrated into any national health insurance program. Not now, not ever.

This leads me to the same conclusion regarding another bill, S. 759—proposed by the VA—and being pushed very aggressively by OMB and the Senate Budget Committee.

This bill would provide for the VA to start the process toward national health insurance by seeking reimbursement from private insurers providing veterans with private health insurance coverage.

The only purpose of this kind of legislation, as far as I'm concerned, is to take a first step toward the VA's participation in national health insurance.

Since I have concluded—along with you—that such participation would be counterproductive and most unwise for the VA health-care system, I am announcing to you today my firm opposition to S. 759.

I pledge my commitment to do all I can to defeat that bill. I call on you for your help.

My opposition to the provisions of S. 1812 that I have discussed and to S. 759 are part of my larger commitment to a strong, independent VA health-care system.

VA HEALTH-CARE SYSTEM—A VITAL ELEMENT OF NATIONAL DEFENSE

Today—with our Nation seriously confronted by the actions of our adversaries abroad—that commitment takes on additional meaning.

I know I don't have to spell out for the members of the Veterans of Foreign Wars what could be the consequences of a worsening situation in the Middle East and in Southwest Asia.

I don't need to tell you that your Washington Conference is taking place in the Nation's capital at a time when there is a renewed urgency in considering matters of war and peace, of military preparedness, and of the needs of veterans.

The Nation badly needs your advice, your counsel, and the advantage of your experience at this time of crisis and challenge.

Organizations like the VFW can drive home the point that the costs of war do not stop when the last soldier sheds the uniform.

We must make every American aware that the defense of our Nation and the great cost of war includes our commitment to those who wage the war after they have served and to their families and their survivors.

The citizens and taxpayers of this country can no more afford to cut short what we owe to veterans than we can afford to give our soldiers less than what they need to fight the battle.

Just as surely as we must provided the weaponry and the ammunition for the warfare itself, we must assure the resources to restore our warriors who are injured while serving our Nation. It would be the height of folly to think we can spend more for national defense by spending less for those who defended the Nation in the past.

Once again the question of conscription and voluntary military service are on the minds of the American people and their representatives in Congress. These questions are very much on my mind, and, I know, on yours.

How in the world can we think America can have an adequate military force—with eager enlistments and with high morale—if we renege on our promises to those who served in uniform in years gone by?

If we break our word to today's veterans will those in the service today and needed tomorrow believe our promises? I think not. And if they don't believe our promises, our ability to mount and maintain a capable, motivated, ready fighting force will surely be impaired.

The grave events occurring halfway around the world also cast the role of the veterans' health care system in a different light.

It is essential that we keep in mind the role that the VA might be called upon to perform in the tragic event that another generation of Americans is called to fight in defense of our country.

Most of you are familiar with a Defense Department report which shows that our governmental medical resources are inadequate in the event of war. The General Accounting Office has criticized this so-called "Maximum Report" for selling short the major role that VA hospitals can perform in the event they are needed to care for wounded troops. The GAO's point is well taken.

The VA health care system—the largest hospital system in the U.S.—is and always has been an outstanding national defense resource.

It is—and it has always been—available as a backup to our military hospitals if, God forbid, we should ever again need it during time of war.

This kind of contingency planning draws this point into extremely sharp focus: now is the worst time—and there has never been a good time—to slight our all-out support for VA hospitals and health-care facilities.

I am working closely with officials in the Defense Department and in the Veterans' Administration to develop a clear understanding of the VA's role in defense contingency planning.

Discussions with top officials in both agencies make it clear to me that the VA is not only the number one backup to the military's rather meager health-care resources, but that the VA health-care system is absolutely indispensable to our military preparedness.

So, as we work together to make our VA hospitals strong, well-funded, and well-staffed to serve the needs of veterans who have earned their right to medical care, we must keep in the forefront of our minds and the minds of the American people that the VA is a vital element of our national defense.

I don't want to give the impression that I think we are on the brink of war. I do not believe we are.

Whatever the long-range consequences of events in Iran and Afghanistan, this much is certain: the United States has a new opportunity to stand tall in the eyes of the rest of the world.

Our people are united behind major foreign policy goals.

For the first time in many years the United States finds its policies supported, and those of the Soviet Union despised, in much of Latin America, Africa, and Asia—the so-called third world. We are demonstrating to the world the distinctly different outcomes of the American revolution and the Russian revolution.

The Soviet experiment is barely 60 years old, yet is already geriatric, fearful, reactionary, closing in upon itself with an obsessive need for central control and security.

By contrast, the American revolution, at age 204, is ever enlarging the freedom and enhancing the range of choices available to its people.

We strive to extend the rights we believe inherent in humanity and in our democratic inheritance.

We show by our treatment of veterans that our word is good and honorable and our foresight clear.

We move to keep America strong in order to keep America at peace.

And as, together, we do these things, we honor our finest American traditions and we fulfill our most cherished ideals.

Chairman **Cranston**. I would, however, like to stress two points that I made on Sunday. First, I am totally opposed to the inclusion of the Veterans' Administration hospital and medical system in any national health insurance program.

It must not be included in any way and certainly not included to receive reimbursement from funding sources regulated by the Secretary of Health, Education, and Welfare for the non-service-connected care that the VA would render to veterans.

That is the approach in President Carter's proposed National Health Plan Act, S. 1812, and it is a bad idea. I intend to assure that it is stopped, now, before that bill is considered further.

If such a reimbursement policy is adopted, it would make the VA dependent on funding from agencies whose priorities are other than meeting the health-care needs of the Nation's veterans. It would turn the VA into a middleman operating between HEW approved insurance companies and veterans needing health care.

I believe that that scheme would seriously undermine the VA's ability to provide quality health-care services to eligible veterans and bring about a sharp decline in the VA health-care system. Thus, I will soon be introducing legislation to remove from S. 1812 those provisions that would include the VA in a national health plan and to substitute a provision making clear that the VA is to remain dependent on funds appropriated by the Congress.

The VA must never be made dependent on funds provided through national health insurance policies and I will propose the same amendment to any other national health insurance bill, including Senator Kennedy's.

Second, I oppose any efforts to reduce funding for VA hospital and medical care. My commitment, and yours, to a strong, independent VA health-care system takes on additional meaning and significance today at a time of crisis and challenge when our Nation is seriously confronted with hostile adversaries abroad and ravaging inflation at home.

I know I don't have to spell out for the members of the Veterans of Foreign Wars what could be the consequence of a worsening situation in the Middle East and in Southwest Asia. Your Washington conference is taking place in the Nation's capital at a time when there is a renewed urgency in considering matters of war and peace, of military preparedness, and of the needs of veterans.

The Nation badly needs the benefit of your experience at this time. You can help us drive home the point that expenditures to maintain our national security do not stop when the last soldier sheds the last uniform. The defense of our Nation and the great cost of war include our commitment to those who must wage the war after they have served and to their families and survivors.

Just as surely as we must provide the weaponry and the ammunition for the warfare itself, if it comes, and God forbid it should come, we must assure the resources to restore our warriors injured while serving our Nation.

It would be the height of folly to think we can afford to spend more for national defense while spending less for those who defended the Nation in the past.

How in the world can we think America can have an adequate military force, with willing enlistments, good retention, and high morale, if we are seen reneging on our promises to those who served in uniform in years gone by?

If we break our word to today's veterans, will those in the service today and those needed tomorrow believe our promises?

I think not, and if they don't believe our promises, our ability to mount and maintain a capable, motivated, ready fighting force will surely be impaired.

The grave events occurring halfway around the world also cast the role of the veterans' health-care system in a different light.

It is essential that we keep in mind the role that the VA might be called upon to perform in the tragic event that another generation of Americans is called to fight in defense of our country.

The VA health-care system, the largest hospital system in the United States, is and always has been an outstanding national defense resource.

It is, and it has always been available as a backup to our military hospitals if, God forbid, we should ever again need it during time of war. In fact, it is the first line of health care after the rather meager Defense Department health-care network.

This kind of contingency planning draws into extremely sharp focus the point that now is the worst time, and there has never been a good time, to slight our all-out support for VA hospitals and health-care facilities.

As I said on Sunday, I don't want to give the impression that I think we are on the brink of war. I do not believe we are, nevertheless, we all need to keep in mind that the VA health-care system is absolutely indispensable to our military preparedness.

So as we work together to make our VA hospitals strong, well-funded and well-staffed to keep faith with and serve the needs of disabled veterans who have earned their right to medical care, we must make sure that the American people understand that the VA is a vital element of our national defense.

In the current atmosphere of budget cuts to put the brakes on runaway inflation, although we'll try to achieve economies and efficiencies where there is waste, and we all may have to work together to tighten our belts where the national need is compelling, there will be no breaking of faith, no breach of our commitments and no slackening of our support for a strong and independent VA health-care system.

There can be no retreat on this. No decline. You have my word on that.

I would like to add that I will be doing my best to make this point—that veterans' care and the commitment to veterans must be considered a part of the cost of defense and is a bill we cannot afford not paying—as well as the point that the VA medical care system is a backup for the military hospitals which would be inadequate if we got into a serious shooting war.

I made that point to the President personally last night and to his top economic advisers in a session where we were contemplating what must be done in regard to the budget to enable us to stem inflation and I will continue to do my best to make that point in appropriate places.

I know that I have your support on these issues and I look forward to receiving your statement of legislative goals and priorities for the coming year. Before proceeding, let me say that I know there are many strong members of the VFW from California here today, including Ray Ohrel and Al Martin, who introduced me Sunday, and I would like to ask that Ray and Al and all the members from California stand up and be recognized.

It was good to see you Sunday and I look forward to seeing you at the Congressional banquet tonight.

I now yield to my distinguished friend and colleague, the Senator from Wyoming, ranking minority member of this committee and a fine member of it and one who is helping us maintain the effective work we do together and the bipartisan approach we have maintained over the years, Senator Al Simpson.

Senator SIMPSON. I very much enjoy my participation on the committee, particularly I enjoy my relationship with the chairman. It's true we have worked in an area that hopefully is nonpartisan and hopefully productive. I also want to welcome the Veterans of

Foreign Wars to Washington for this presentation of their priority legislative program for this session of Congress.

You did not come here to hear me, we came to hear you, Howard. You and I shared the banquet table last year, when I first met you and saw that you were fully ready to embark on a very busy year. I think you have done a commendable job and it was my pleasure to have gotten to know you personally.

I acknowledge my good colleague, Bill Bradley from New Jersey, another distinguished member of the class of 1978, as am I, and a very classy person, indeed. I have great pride in the VFW, I am a lifetime member of the Poley Post and the Wyoming delegation is here in force; you can bet on that. Where are they? Ah, there they are.

Much more than California, did you see that?

Chairman CRANSTON. No; I didn't see that.

Senator SIMPSON. Let me say that your advice and your counsel are very important to us and we do listen to you. As Senator Cranston said, these are times of budget reassessment and budget stress, adjustments will be required at every level of society.

The committee itself has shown the way in that instance. We presented our operating budget to the Senate Rules Committee with no requested increase. Needless to say we were the only committee not to request an increase.

This committee is committed to the veteran and that's why it was formed. We have never failed to meet the needs or attempt to repay the sacrifices that were given. But you will have to join us in a serious reassessment of national priorities which will be dedicated to protection of the veteran, his rights and the things we owe to them for the service rendered to our country.

Thank you so much and I look forward to your presentation. If I do have to leave prior to its conclusion—I have a subsequent meeting of ranking minority members in the Capitol Building—I will read it carefully and I assure you I will be there this evening. Thank you so much for coming, all of you.

Chairman CRANSTON. Thank you very much, Al, and I yield to another outstanding member of this committee, my friend and yours, Senator Herman Talmadge of Georgia.

Senator TALMADGE. Thank you very much, Mr. Chairman. My comrades of the Veterans of the Foreign Wars, it is a pleasure for me to welcome you back to Washington, and I am particularly happy to see my longtime close friend and former national commander, Bulldog Smith in the audience.

Will the Georgians please stand up?

I want to commend our distinguished chairman for his statement, and I endorse everything he has said. I have been involved in the area of compensation and pensions for veterans even before our Veterans' Affairs Committee was formed.

Back in the days when the Finance Committee handled legislation relating to veterans' compensation, I was chairman of that subcommittee. At that time and since then, I have worked closely with the chairman and other members of this committee and offered legislation to increase the benefit levels for service-connected disability compensation and DIC.

We on this committee, are absolutely determined that our veterans shall have the very best available health care, and we will certainly keep that health care independent, affecting veterans only.

Finally, I am happy to report to you that about 30 minutes ago, conferees on the Ways and Means Committee and the Finance Committee accepted a provision which we put in H.R. 3434 to protect the medicaid eligibility of VA pensioners in States where medicaid eligibility is dependent upon being in the category of needy.

I cosponsored this amendment and hope it will be agreed to by the House and Senate and the President forthwith.

Chairman CRANSTON. Thank you very much, Herman, and I appreciate your statement agreeing with my statement.

I now recognize the distinguished Senator from Vermont, who has served us as ranking minority member of this committee from time to time, a very diligent member and a good friend of yours and mine, Senator Bob Stafford of Vermont.

Senator STAFFORD. Thank you very much, Mr. Chairman, for your kind words. It's always been a great pleasure for me to serve on this committee.

I join you in extending a warm welcome to the leaders and representatives of the membership of the Veterans of Foreign Wars who are my comrades. It is a genuine pleasure to again meet with Commander in Chief Vander Clute, to have you and other distinguished officers and members of the VFW with us this morning for this your annual presentation of legislative recommendations. I'm glad to see, Howard, you survived your visit to Vermont nicely and we were much honored to have you up there.

Commander VANDER CLUTE. Thank you, sir.

Senator STAFFORD. Our Committee on Veterans' Affairs of the Senate gives most careful and complete consideration to the suggestions, resolutions and mandates of the Veterans of Foreign Wars. I take special pride in my own membership in the VFW which I established in 1947 and I have been a member ever since.

I want to particularly welcome the delegation from my own State of Vermont. I will be meeting with all of them in my office a little later and with all of you at your banquet this evening. Since a precedent has been set, I will ask the Vermonters present if they would stand?

It has been a genuine pleasure to work closely with the excellent Washington VFW staff during this past year; with Cooper T. Holt, executive director; Donald Schwab, the national legislative director; and his assistants, Al Poteet and Phil Mayo.

It should be noted that the goals of the Veterans of Foreign Wars have been for the most part followed by our committee. We do greatly appreciate the strong support of the Veterans of Foreign Wars in preparing and seeking passage of legislation to benefit our Nation's veterans.

Each of you, and those whom you represent, guide this committee in its efforts to improve the lives of America's veterans. I will say to our friends from VFW, before I recognize the distinguished Senator from New Hampshire, that I would like to, by unanimous consent, place in the record a statement by Senator Strom Thurmond, who to my knowledge has attended almost all of these annual meetings since I have been a Member of the Senate.

I regret that circumstances have forced Senator Thurmond to miss the meeting today, but I will ask unanimous consent that his statement be made part of the record at this point.

Senator **SIMPSON** [presiding]. Without objection, so ordered.

[The prepared statement of Senator Thurmond follows:]

PREPARED STATEMENT OF HON. STROM THURMOND, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

Mr. Chairman, it is a pleasure to receive testimony from the Veterans of Foreign Wars concerning their 1980 legislative goals. I would like to extend a warm welcome to VFW Commander in Chief Howard Vander Clute. Also, I would like to welcome former Commander in Chief Cooper T. Holt, now executive director; Don Schwab, legislative director; and, other members of their staffs with whom we on the Committee work on a daily basis. The Washington Office of the VFW provides great assistance to this Committee in all areas of veterans affairs, and the membership can be proud of their Washington Office. It also is good to have my fine South Carolina friend, Jimmy Cothran, former Commander in Chief, here today.

I look forward to this annual presentation in which you outline not only the legislative initiatives for 1980, but you provide much information as to the problems that have occurred in the vast VA system during the past year.

Mr. Chairman, during this past weekend, it was announced that the President had requested each agency and department to submit recommendations which would result in a substantial reduction in their fiscal year 1981 budget. I believe the VA budget, which was submitted in late January, is very conservative, and any large reductions would result in the denial of services and hospital care to our veterans population. I want to assure each of you that I will carefully review the new budget submissions by the Administration and any meat-ax approach will not be tolerated.

Mr. Chairman, there are several members of the South Carolina Department who are in attendance today, and I would like for them to stand. Our State Commander Harry Faris, Adjutant David Hutto, and Arnold Muir are present today. Also, would any other South Carolinians please stand.

Senator **SIMPSON**. Another fine member of the committee, Senator Matsunaga of Hawaii.

Senator **MATSUNAGA**. Thank you very much, Mr. Chairman. I, too, wish to join the members of the committee to welcome you, Commander Vander Clute, and congratulate you on the fine record you have made as VFW commander. As a life member of the VFW, I don't think I need any lobbying.

However, the fact that you are here to present your program I think will have great influence on the others who do need some lobbying.

The fact that you are being introduced today by one who always swishes things in, I think it is to the credit of VFW. I welcome you and I hope the members of the Hawaii delegation are in the audience because I had to make a special effort to be here and I want the members of the Hawaii delegation to know their Senator is on the job.

Chairman **CRANSTON**. Thank you, Sparky.

Now the newest member of the committee, Senator Gordon Humphrey of New Hampshire.

Senator **HUMPHREY**. Thank you, Mr. Chairman, I don't think anyone wants to hear another speech so let me welcome Commander Vander Clute and all the members of the VFW and ask that my welcoming statement be put in the record. Before relinquishing the floor, I would like to ask Commander Fred Harvey of New Hampshire to stand and show our contingent.

[The prepared statement of Senator Humphrey follows:]

PREPARED STATEMENT OF HON. GORDON J. HUMPHREY, A U.S. SENATOR FROM THE STATE OF NEW HAMPSHIRE

I am pleased to join my colleagues today to review the legislative program of the Veterans of Foreign Wars. I want you to know that I value highly the views of the VFW. I find the VFW and other veterans' organizations to be effective voices for veterans throughout America. I applaud your efforts.

As I have stated on a number of other occasions, I believe this country owes a certain debt to our veterans. I will continue to fight for existing veterans benefits which veterans earned and which veterans deserve. I will work to make sure that the VA hospital system remains strong. I know that you and I will have to fight hard to make sure the VA hospitals are adequately staffed.

At this time I would like to recognize the men who have come all the way from New Hampshire for this important meeting. Many of these individuals have been very helpful to me in my first year in the Senate. Please stand when I call your name.

Commander Fred Harvey.
Senior Vice Commander Paul Nicholas.
Junior Vice Commander John Smart.
Quartermaster Leo St. Cyr
Harry Laderbush.
Richard Crane.
Charlie Shaw.
Russell Corcoran.
John LaRosee.

Again, I intend to help you in your efforts to ensure that our country keeps the pledges we have made to our nation's veterans. Veterans deserve no less.

Chairman CRANSTON. For purposes of introduction, it is my pleasure to yield to and recognize the outstanding Senator from New Jersey, Senator Bill Bradley, who has made a great mark in a very short time in the U.S. Senate.

TESTIMONY OF HON. BILL BRADLEY, A U.S. SENATOR FROM THE STATE OF NEW JERSEY

Senator BRADLEY. Mr. Chairman, members of the committee, let me say at the outset, since I serve on the Energy Committee and the Finance Committee, that it's an unusual experience to come to a committee hearing and find that the committee members are applauded for their statements.

It is a pleasure for me to come before the committee today and make the formal introduction of Howard Vander Clute who is a fourth generation New Jerseyan, resident of Montvale, N.J., and who, on August 24, 1979, was elected commander in chief of the Veterans of Foreign Wars of the United States.

Mr. Vander Clute has had an outstanding record of over 20 years of service in the Veterans of Foreign Wars. He has served in every elected office in his post, the county council and the department—has passed the all-American district in the department—commander and was New Jersey department commander in 1974–75.

I would like to say also, Mr. Chairman and members of the committee, that Mr. Vander Clute has a history of serving as this committee serves the veteran community and that is, in a bipartisanship nature. In 1972, he was appointed by a Republican Governor of New Jersey as chief advisor and confidante on veterans affairs and in 1975, he was appointed by a Democratic Governor to serve the same function. So I know that his words today will be in that bipartisan manner and will also come from a base of great experience and intelligence as it pertains to veterans affairs. It is my pleasure today to welcome him to the U.S. Senate, this hearing room, and to introduce him formally to the committee. Thank you, Mr. Chairman.

TESTIMONY OF HOWARD E. VANDER CLUTE, JR., COMMANDER IN CHIEF, VETERANS OF FOREIGN WARS, ACCOMPANIED BY COOPER T. HOLT, EXECUTIVE DIRECTOR; TED C. CONNELL, PAST COMMANDER IN CHIEF AND CHAIRMAN, NATIONAL LEGISLATIVE COMMITTEE; AND DONALD SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE

Commander **Vander Clute**. Mr. Chairman, I would first like to thank Senator Bradley for taking time from his busy schedule to come over and introduce me to this very distinguished committee this morning.

Mr. Chairman and members of the committee, it is, indeed, an honor and privilege for me to again appear before this most distinguished and important committee representing the more than 2.5 million men and women of the Veterans of Foreign Wars of the United States and our ladies auxiliary.

This time, to present to you our priority legislative program for this 2d session of the 96th Congress. Our pamphlet entitled, "VFW Priority Goals—Legislative and Security for 1980" is appended to my testimony. Without objection, it is requested these priority goals be made a part of the record of this hearing.

Now, Mr. Chairman, it is my pleasure to commend this committee for having advanced the several bills beneficial to our veterans, their dependents and survivors, which became Public Laws 96-22, 96-128, and 96-151. In conjunction therewith, although we are aware of the need of cost savings legislation in the present fiscal climate, particularly in areas of waste and abuse, we believe veterans' benefits and services are the very last place any cuts whatsoever should be made. Therefore, we trust this committee will reject any administration proposal to cut veterans' benefits.

I would be remiss, Mr. Chairman, in failing to commend your fine professional staff and, in particular, Jonathan R. Steinberg, your chief counsel; Edward P. Scott, general counsel; former Congressman Garner Shriver, minority counsel and John Pressly, minority associate counsel. These men have worked closely with the executive director of our Washington office, Cooper T. Holt and our national legislative director, Donald H. Schwab and their staffs to our mutual benefit.

Accompanying me today, Mr. Chairman, are those who comprise the national leadership of our organization. Those whose continued dedication and hard work, freely given of their own time, have made this our 25th consecutive year of increased membership. Incidentally, half a million, or 27 percent of our members are Vietnam veterans who served "in country" or in contiguous waters during the period of armed conflict.

Mr. Chairman, for many years I sat in the audience at this hearing behind the witness table and listened to my predecessors denounce inadequate budgets recommended by the administration for the Veterans' Administration. Now, this administration has unfortunately forced me to walk in those same shoes.

It brings me neither personal pleasure nor satisfaction to state here today that the President has again most clearly signaled his continuing and perplexing antiveteran posture by recommending for the Veterans' Administration an inadequate, diminishing budget with respect to the Federal budget and proposing negative legislation to eliminate benefits for our Vietnam veterans.

The President's proposed Federal budget for the fiscal year 1981 is $677.6 billion in budget authority and $612 billion in outlays, up 9 percent over 1980. Although the proposed VA budget of $22.7 billion budget authority and $21.7 billion in outlays is an increase of some $985 million or approximately 7 percent over 1980, it is again down in proportion to the Federal budget, while the veteran population is the largest in our history at 30 million.

In 1975, the VA portion of the Federal budget was 5.1 percent; in 1979, 4 percent; in 1980, 3.7 percent and projected for 1981, 3.5 percent. At this point in time, Mr. Chairman, nearly 7 months prior to the next fiscal year and with an inflation rate already anticipated at 13 percent, it would appear the proposed VA budget will be at least nearly three-quarters of a billion dollars understated.

We can now already identify shortfalls of $460 million due to inflation in medical care; $65 million in medical care personnel; $180 million in GI Bill benefits, and between $10 million to $40 million for grants to State homes.

Mr. Chairman, the compensation program for the 2.2 million veterans to remunerate them in part, and only in part, for loss of earning capacity due to their service-connected disabilities and the dependency and indemnity compensation benefits for the more than 360,000 survivors of permanently and totally disabled veterans constitute the very heart of all the benefit programs.

The budget has provided for a 13-percent increase in these benefits which may or may not prove realistic when the new fiscal year is upon us. However, the position of the VFW is, and historically has been, that increases in compensation and DIC be in direct proportion to the increase in the Consumer Price Index since the last cost-of-living increase.

An increase of 13 percent in the assured income level of those in receipt of pension under the provisions of Public Law 95-588, the so-called Veterans' and Survivors' Pension Improvement Act of 1978, is also reflected in the budget.

This, of course, is an uncontrollable item since the cited law indexed the pension program to the increase in social security benefits. Due to erroneous information, being disseminated by a top VA official, permit me for the record to make it abundantly clear that the VFW did not support the legislation which became Public Law 95-588.

We did, however, support the more liberal House version of H.R. 10173, with recommended modifications, which unfortunately were not in the legislation cleared for the White House.

Mr. Chairman, we know as you know that the 10-percent cost-of-living increase for those availing themselves of educational benefits under the GI Bill is a sham. This election year is the very first budget in which the President has recommended any such increase notwithstanding all the high-sounding rhetoric poured out by the administration with respect to how very much we owe our Vietnam veterans.

The last increase granted these students was for 6.6 percent by Public Law 95-202, the GI Bill Improvements Act of 1977, effective October 1, 1977. According to the Congressional Budget Office, these veterans of our most unpopular war needed a 20-percent increase last October and will need approximately 30 percent in October of this year to catch up.

The deserved cost-of-living increase would cost in the vicinity of three-quarters of a billion dollars which, of course, means it will not be forthcoming. However, to be at all meaningful, there must be at least a 15-percent increase as now included in legislation passed by the Senate at your insistence, Mr. Chairman, and this before we consider passage of any new or expanded programs under the provisions of chapter 34, title 38, United States Code, even though we would then, by mandate support specific liberalization.

We are pleased to note, Mr. Chairman, that funding to enhance the vocational rehabilitation program is to be increased from the wholly inadequate $3.2 million this year to $7.9 million in fiscal year 1981, and we hope that enacting legislation will be timely advanced.

However, we wonder how successful an expanded program will be since information available to us indicates that the Office of Management and Budget has only authorized 55 of the 175 personnel requested by the VA for vocational rehabilitation.

Mr. Chairman, it is quite obvious to all concerned that the ills of the Veterans' Administration and its hospital and medical care system are now growing at an escalating rate and due in nearly all instances to repeated straight line budgets and thus regressive budgets which the administrator has been attempting to camouflage with reams of glowing statistics and charts designed to support his contention that everything is fine and that they are doing a better job with fewer people and less funding.

You know this is not the case, we know this is not the case, the professionals within the VA system know this is not the case and, above all, our veterans know this is not the case.

You will recall when I testified last October, during the joint oversight of this committee, and the Veterans' Affairs Committee requested by me, that not only the major veterans' organizations, but professionals from within the VA hospital system documented with irrefutable testimony that the care of our Nation's veterans has greatly deterioriated.

The slashing of 6,800 hospital beds and over 7,000 health care personnel in 2 years, and the increase in demand for care by our most crippled Vietnam veterans and an aging population can only produce declining care and the increasing referral of veterans to community welfare facilities.

As a result of this hearing, the administration agreed to restore 3,800 health care personnel as mandated by Congress under the provisions of Public Law 96-151, the Veterans' Programs Extension and Improvement Act of 1979. However, the entire first quarter of fiscal year 1980 passed without such being accomplished.

In January of this year, the VA advised us they had filled 2,200 of the 3,800 positions in question, but failed to mention that of the 179,000 health care personnel, they experience a turnover of 2,000 per month so that to have, in fact, hired 2,200 new personnel, they would have had to have hired 4,200 to include compensating for the turnover rate.

While this hearing was in progress, the President's Office of Management and Budget issued a directive requiring all agencies to absorb 40 percent of the cost-of-living increase granted employees October 1, 1979, which in the case of the VA would have wiped out all of the $76 million for the 3,800 employees if taken from the medical budget.

Subsequently, the Administrator advised us he was only going to be required to absorb 11 percent of the cost-of-living increase and the money would be found somewhere other than in medical care. It now appears that the VA will be required to absorb 20 percent of the cost-of-living increase.

All of the chicanery is at the direction of the President's Office of Management and Budget which with impunity circumvents and thwarts the will of Congress. Compounding this adverse personnel and funding situation, the proposed budget calls for an increase of only 50 new full-funding medical personnel for new facilities and 26 additional positions within the Department of Medicine and Surgery. This means that existing understaffed facilities will be further drained to staff new facilities.

The Vietnam veterans' readjustment counseling authorized by Public Law 96-22, the Veterans' Health Care Amendments Act of 1979, highly touted by the administration as being beneficial to Vietnam veterans, will be underfunded and understaffed to the extent that only $12.5 million of the $25 million needed was approved by the conferees on the budget.

Recent hearings brought to light the fact that over 40 percent of the physicians throughout the Veterans' Administration hospital and medical care system are part-time doctors and that in over 32 facilities from 50 to 91 percent of the doctors are part time.

In addition, foreign medical graduates comprise 38 percent of hospital staffing and continues to grow. We are hopeful that making permanent the incentive pay program and monetary increases therein will go a long way toward the recruitment of more full-time physicians and dentists and more who are graduates of American medical schools.

Mr. Chairman, we are concerned with respect to increasing dominance of VA hospitals by affiliated medical schools. It has been alleged that dominance by the Deans Committee over directors, chiefs of staff, and chiefs of service in VA hospitals dictates admitting policies not necessary predicated on the basis of need but on educational potential. This situation must be rectified if affiliation is to be mutually beneficial.

Mr. Chairman, one bright spot in the budget is the increase in funding for the construction, replacement or alteration of medical care facilities. Since this fund was permitted to fall to $259.1 million at one point and is reflected in the budget as $416.1 million and under the VA 5-year construction plan provided by Public Law

96-22, will rise to $805.1 million in 1983 and then drop $744.3 million in 1984.

This about face in construction funding caused us to recall an old proverb to "Beware of Greeks bearing gifts." We all naturally wondered, and still do, whether the administration has finally recognized this urgent need, whether it was merely election year puffery or subterfuge.

Believe me, Mr. Chairman, after viewing the administration's national health plan, S. 1812, which would guarantee treatment in VA facilities to veterans with service-connected disabilities and for only those disabilities and designate the VA as a provider under the plan, our fears have not been laid to rest, but accentuated.

We have, as you know, stated for years that the grand design of the President's Office of Management and Budget is to take over our VA health care system to implement national health insurance. Although this assertion has been repeatedly denied, S. 1812 is the vehicle which would accomplish this shameful act.

Needless to say, in testimony before the Subcommittee on Health of the Ways and Means Committee, we opposed passage of the House companion bill, H.R. 5400, in the strongest possible terms last month. Let me make it abundantly clear to all, Mr. Chairman, we of the Veterans of Foreign Wars and our ladies auxiliary will fight the passage of S. 1812 or similar legislation with every resource at our disposal.

The Senate bill is quite properly numbered—1812 designates a war between the United States and Great Britain and S. 1812 means war to the VFW.

The effort and money we spent to save the Senate Veterans' Affairs Committee will pale in comparison to the extent to which we will go to save our VA hospital and medical care system from the invasion of national health insurance.

The administration has again spawned the rumor that the veterans' organizations don't have clout. Let me say this, let them advance this legislation and they will see clout they never dreamed of, guaranteed.

Speaking of the proposed construction plan, Mr. Chairman, and based on past experience, it is quite obvious the VA will not operate the 12,000 nursing care beds in this fiscal year 1980 as authorized by title 38, United States Code, section 5001(3) as amended by Public Law 96-22.

No, not even through the fiscal year 1984. As a matter of fact, the administration, according to the fiscal year 1981 budget, plans to have only 13,100 nursing home beds by 1987. In view thereof, I reiterate our previous request to both this committee and the Administrator of Veterans' Affairs that action be taken now so that no more acute hospital beds be closed, but that they be redesignated as intermediate or long-term beds to care for the 3 million veterans over age 65, a figure which will increase to nearly 7 million in the next decade.

This, since it is nearly impossible for a veteran to be admitted to nursing care or domiciliary care facilities within the VA. A disgraceful situation since those in need cannot afford the $800 or more each month in private facilities.

Mr. Chairman, you have held hearings with respect to S. 1523, the Veteran Senior Citizen Health Care Act of 1979, introduced by the Honorable Strom Thurmond. Due to the pressing need for this legislation, its passage is one of our priority goals. Therefore, I ask you to advance undiluted either S. 1523 or the companion bill, H.R. 4015, passed by the House of Representatives last June.

Another area of increasing concern is the proposed contracting out of services within the VA, a study of which is required by Office of Management and Budget Circular No. A-76. We understand such contracting out demonstration projects are now being undertaken in VA facilities at Togus, Maine; Washington, D.C.; Boston, Mass.; Battle Creek, Mich.; Memphis, Tenn.; Loma Linda, Calif.; and either Iowa City, Iowa, or Sioux Falls, S. Dak.

Contracting out is a way of circumventing veterans' preference in Federal employment and is being used to greatly reduce the number of jobs available to veterans and disabled veterans which the President and his Director of the Office of Personnel Management were unable to do in their proposals to Congress which would have practically eliminated veterans' preference in Federal employment.

In addition, contracting out is a method of circumventing personnel ceilings for cosmetic effect and in the final analysis, dilutes control of personnel and job performance. Along this same line, you may have read an article in the February 18, 1980, edition of U.S. News & World Report, entitled "U.S. Government's Invisible Workers."

This article states in part:

> Experts believe, that while officially the Federal rolls, including postal workers, have stayed around 2.9 million since 1970, the number of workers paid directly by Washington has soared to perhaps 8 million people.

Thus, over 5 million workers have been added to the Federal payroll by the contracting out of services.

Mr. Chairman, another of our priority goals deals with the studies of the effects of both radiation and herbicide exposure and the service connection of disabilities or infirmities medically recognized as being related to such exposure.

Although some progress has been made with respect to such exposure, many veterans are failing to respond to outreach efforts of both the Veterans' Administration and major veterans' organizations. It is imperative that those who believe they were exposed to dioxin in Vietnam, file a claim with Veterans' Administration so that they may be examined and any suspected symptoms be made a matter of record.

In October 1978, the House Veterans' Affairs Committee held extensive hearings with respect to Agent Orange and, Public Law 96-151, the "Veterans' Programs Extension and Improvement Act of 1979," provided, among other measures, that the Administrator of Veterans' Affairs conduct a study of the long-term effects of dioxin exposure.

We believe the outreach program of the VA shoud be intensified and we will increase our efforts through our national publications and our nationwide network of service officers to contact veterans who believe they suffer from dioxin exposure.

However, we also firmly believe the granting of service connection can only be made after ongoing studies have been completed and the ill effects on the lives of exposed veterans has been medically established.

Mr. Chairman, unemployment among our disabled and Vietnam veterans has again reached intolerable proportions. In January, the last month for which figures are available, the unemployment rate reached 18 percent for younger veterans; for veterans in the 25 to 29 age group, 9.4 percent; while for their nonveteran counterparts, it is 6.1 percent.

It is significant to note that between December and January, national unemployment rose 340,000 and for all veterans the increase was 158,000 or 46.4 percent of the total increase. It would appear that the administration's emphasis on placing women and minorities, coupled with a depressed economy and contracting out, is having a distinct adverse effect upon veterans' employment.

Mr. Chairman, it is obvious that in order to reduce unemployment, make viable the psychological readjustment and expanded drug and alcohol abuse programs, vocational rehabilitation and agent orange claims the veterans' outreach services program authorized by title 38, United States Code, section 240 must be greatly expanded.

Trained personnel are available in the greatly reduced veterans' representatives on campus program (Vet Reps) authorized by title 38, United States Code, section 243. In 1973, there were 1327 Vet Reps and all but 237 were eliminated as of last month. We believe these skilled Vietnam era veterans should be transitioned into the outreach program rather than terminated.

Mr. Chairman, we are distressed by reports that adjudication officers in VA regional offices are given unrealistic quotas of claims of veterans they must process each day. Claims of varying degrees of complexity simply cannot be properly evaluated on a quota system.

Our veterans are entitled to a full, fair, and impartial review of any claim filed. Since our information came from reliable sources, I would suggest to you, Mr. Chairman, that this would be a proper matter for this committee to pursue.

Mr. Chairman, the bottom line of my testimony, the thrust thereof as expressed here on Capitol Hill, is that the administration must provide adequate budgets for the Veterans' Administration to properly carry out the mandates of Congress and serve our Nation's veterans, their dependents and survivors as intended by a grateful nation through the wisdom of Congress.

With repeated diminishing budgets with respect to the Federal budget, coupled with a growing inflation rate and an increasing need of medical care, we have not merely a straight line budget, but a regressive budget. As you are well aware, even these budgets were neither of the administration's choosing, nor increased through the efforts of the Veterans' Administration, but increased only through the hard work of this committee, its counterpart in the House, the Veterans of Foreign Wars, and the other major veterans' organizations which testify with respect to the budget and appropriation.

I most highly commend you, Mr. Chairman, for having fought for increased budgets with the Budget Committee, the President and, yes, on the floor of the Senate.

Mr. Chairman, departing from my prepared text, events of the past several days necessitate a reevaluation of some priorities in the Federal budget. As you know, the President has directed a 2-percent reduction in personnel and a 10-percent cut in other areas throughout Government agencies.

We in the VFW are aware that the present spiral of inflation must be curbed, and there are areas of waste and program abuse wherein substantial savings could and should be made. However, the Veterans' Administration is not one of them.

As stated previously, the Veterans' Administration has suffered repeated diminishing budgets under the current administration, having fallen from 5.1 percent of the Federal budget in 1975 to a projected 3.5 percent of the budget for fiscal 1981.

The resultant reduction in medical care personnel and the closing of nearly 7,000 hospital beds has caused our veterans to be referred to welfare sources for treatment which in turn tells our veterans: You are a veteran; go to the VA.

Consequently, these needy veterans go untreated. This is an intolerable situation which must be rectified. The VA has already absorbed a highly disproportionate share of cuts, and further cuts would be a complete disaster. Our Nation's veterans have made a very special contribution to our great Nation, and we of the VFW will not sit idly by and watch them given further short shrift.

Mr. Chairman and members of this distinguished committee, I trust each of you will be with us tonight on the occasion of our annual congressional banquet at the Sheraton Washington Hotel. As you know by now, we will be honoring the Honorable G. V. (Sonny) Montgomery with our 17th Annual Congressional Award for Outstanding Service to the Nation.

The reception will begin at 6 p.m., with dinner promptly at 7 p.m., where our Voice of Democracy contest winners will be honored guests. I want to assure all of you, our program will conclude at approximately 9:15 p.m.

Thank you, Mr. Chairman and members of the committee.

Chairman **Cranston**. Thank you very much, Commander, for a fine, forceful statement. We will be working together, and we will see you tonight.

I would like now to recognize the distinguished Senator from Florida, an outstanding working member of our committee, Dick Stone.

Senator **Stone**. Thank you, Commander Vander Clute, and my State Commander, Raymond Prentice, and my Florida delegation, and all of you; I appreciate this testimony. It is most helpful.

When those of us on this committee under the leadership of our chairman fought for the proper funding in the budget resolution and were recently criticized for so-called budget busting, it makes us feel good to have you recognize that what we were doing is simply fighting to restore the minimum promised level, promised to the people who made this country survive.

All we want is the appropriate share of the pie, not an unreasonable expansion of the pie. I know that I, with the rest of my colleagues, will continue to make that fight as we fight to curb inflation and cut that part of the budget which has not already been cut as you have been cut.

Chairman CRANSTON. Thank you, Dick. Thank you, Commander. Thank you all. We now stand adjourned.

[Whereupon, the hearing was adjourned at 12:30 p.m.]

[The pamphlet, "VFW Priority Goals—Legislative and Security—for 1980," referred to earlier by Howard E. Vander Clute, follows:]

V.F.W. PRIORITY GOALS

LEGISLATIVE and SECURITY

for 1980

HOWARD E. VANDER CLUTE, JR.
COMMANDER-IN-CHIEF

PRIORITY LEGISLATIVE PROGRAM

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Preamble

"The nation which forgets its defenders will itself be forgotten."

Calvin Coolidge

When Candidate Carter was campaigning in 1976, he indicated if he became President, the American veteran, of all ages, all wars, was going to have a friend, a comrade, and a firm ally in the White House. Never has it been more abundantly clear that there is a vast difference between campaign rhetoric and deeds, once elected.

The present most anti-veteran Administra-ation has embarked upon a program to set the stage for the demise of the VA Hospital and Medical Care System by repeated inadequate diminishing budgets, with respect to the Federal Budget, resulting in the reduction of hospital beds and personnel and the denial of medical care to needy veterans. For the third consecutive year, there was not one penny included for a cost-of-living increase for our Vietnam veterans availing themselves of educational benefits under the GI Bill. (The VA Budget for the Fiscal Year 1975 was 5.1% of the Federal Budget and that for 1980 is 3.7% and we presently have more living veterans than at any time in the history of our nation, 30 million.)

The President pardoned draft dodgers and paid their way home from wherever they were in the world. The President directed the upgrading of the bad discharges of Vietnam veterans under greatly reduced standards, thus cheapening the honorable discharge. The President then wanted to grant these same people veterans benefits which, through the efforts of the V.F.W. was rejected by Congress. The President brought unprecedented pressure to bear on Congress to greatly curtail veterans preference in Federal employment to the extent that the White House prevailed upon the Administrator of Veterans Affairs to telephone Members of the House of Representatives to vote against the Amendment of Representative James M. Hanley (NY) to preserve veterans preference, which, because of an overwhelming national and grassroots effort by the V.F.W., passed and saved veterans preference. For the very first time in our memory, Members of the Senate Veterans' Affairs Committee took to the floor of the Senate and sold their colleagues on passing legislation, introduced by request of the Administration, to cut veterans benefits for those with non-service-connected disabilities and Vietnam veterans, in an onerous trade-off, approved by the President, to restore a portion of the medical care personnel already eliminated by the VA. Additional cost-saving legislation to further reduce benefits for Vietnam veterans has been introduced in Congress at the behest of the Administration. It would appear the President and his Administration are more dedicated to assisting those who did not serve honorably or fled the country in its time of need than our veterans who donned the uniform, shouldered arms and served our nation with honor.

Because of the current economic down trend, unemployment is expected to increase significantly during the coming year. Historically, it has been demonstrated that, in times of high unemployment, veterans, particularly disabled, minority and younger veterans have borne the burden of disproportionately higher unemployment than their non-veteran peers. During periods when the unemployment rate is high, many veterans are forced into positions which do not utilize their education, skills or training. While this practice may inflate employment statistics, it does a disservice to those who were pursuing a career for which trained in that it results in underemployment.

Efforts to curtail or reduce veterans preference in federal employment by the Administration were unsuccessful. Efforts to do likewise in state veterans preference suffered a defeat when the Supreme Court upheld veterans preference in the State of Massachusetts. Notwithstanding these successes, we can expect increasing effort by groups opposed to veterans preference to once again surface seeking legislation to curtail or reduce this hard earned benefit.

The Disabled Veterans Outreach Program (DVOP) continued to appear to be the most significant program toward improving emloyment opportunities for disabled veterans. Ironically, the department of Labor still proposes to reduce the number of DVOP representatives by 25% each year, eventually doing away with this program altogether.

The V.F.W. will continue to insist that more aggressive promotion of veterans employment programs in federal employment and in the private sector be carried out by the Office of Personnel Management and the Department of Labor, respectively, and that outreach efforts to veterans be improved.

Given the foregoing, our duty is clear. We must prevail upon the Congress to enact legislation fulfilling our priority goals. We, as individuals, must elect to Congress only those who believe our veterans have rendered a very special service to our nation and whose ideals are in concert with those of the V.F.W., regardless of party affiliation. We must do this to "HONOR THE DEAD BY HELPING THE LIVING." We must never forget, nor permit anyone to forget, that because of our veterans, and only because of our veterans, we have a free nation where we, you and I, may live with dignity and honor in freedom and progress in accordance with our individual abilities and motivation.

THE V.F.W.
"IN FRONT OF THE REST!"

Legislative Goals For 1980

VA BUDGET

Prevail upon the Congress of the United States to establish and pass a realistic budget for the Veterans Administration sufficient to carry out the mandates of Congress and to restore hospital beds and personnel cuts in F.Y. 1979, and programmed to be eliminated in F.Y. 1980; to provide hospital and medical care to all veterans in need thereof, to include inpatient, outpatient and contracted care when necessary; to replace antiquated facilities and, where needed, establish new ones; and, to not only maintain all existing benefit programs, but provide cost-of-living increases therein.

REORGANIZATION PLANS

Oppose any reorganization plan, legislation or other action, which would abolish all, or part, of the functions of the VA and its programs, or which would transfer any function or program to any other agency.

NATIONAL HEALTH INSURANCE

Oppose any national health insurance plan which would or could invade the VA Hospital and Medical Care System, or any legislation which would or could identify the VA as a health-care provider for other than veterans and the dependents of veterans who are permanently and totally disabled due to their service-connected disabilities.

COST–SAVING LEGISLATION

Oppose the passage of cost-saving legislation which would eliminate, or reduce any existing veterans benefit, entitlement, or benefits for Armed Forces personnel, retirees and their dependents.

VA HOSPITAL AND OUTPATIENT ADMISSION POLICIES

That the Chairmen of the House and Senate Veterans' Affairs Committees conduct an investigation in the form of hearings with respect to the VA's Hospital and Outpatient Facility Admission policies and that a select group of hospital directors, chiefs of staff and chiefs of nursing be called to testify thereon.

GERIATRIC CARE

Support pending legislation to greatly increase the Veterans Administration's lagging geriatric research, education and clinical centers program (GRECC).

RADIATION AND HERBICIDE EXPOSURE

Pursue the authorization of service connection for conditions medically recognized as being related to radiation or herbicide exposure, if the disease occurs after such exposure; to seek the accurate and timely completion of studies to resolve the questions of health defects raised as a result of such exposure.

G. I. BILL

Seek the introduction and passage of legislation to provide a meaningful cost-of-living increase to those Vietnam veterans availing themselves of educational benefits under the G. I. Bill Educational Program; to expand the Vietnam G. I. Bill entitlement from 45 to 48 months, thereby making the amount of entitlement available equal to that afforded veterans of prior wars; and, to delete all references to a specific termination date for those compensably disabled veterans entitled to vocational rehabilitation under Title 38, United States Code.

NATIONAL CEMETERIES

That the V.F.W. continue its support of an open National Cemetery in every state and press for the expeditious opening of cemeteries approved by Congress; namely, those in California, Massachusetts, New York, Pennsylvania and Virginia. Further, that we oppose elimination of the VA burial allowance when Social Security death benefits are paid.

STATE VETERANS HOMES

That the V.F.W. supports grants to state home facilities by the VA of not less than $15 million per annum and payment of an equitable percent of the per diém rate for hospital, nursing home and domiciliary care.

VETERANS PREFERENCE

Maintain veterans preference in federal employment and insist on the strict enforcement of that preference in all departments and agencies in federally funded programs.

VETERANS EMPLOYMENT SERVICE FUNDING

Demand that the Department of Labor include in its budget, as an identifiable line item, the funding needed to fully staff the Veterans Employment Service, and provide for the increased cost of travel for Veterans Employment Representatives and to retain the secretaries of the Veterans Employment Representatives.

DISABLED VETERANS OUTREACH PROGRAM

Retain the Disabled Veterans Outreach Program (DVOP) as a separately funded identifiable program at the 2,000 staff level on a permanent basis.

VIETNAM ERA VETERAN DEFINITION

That the definition of a Vietnam Era veteran under the Affirmative Action Program established by Chapter 42, Title 38, U.S.C. be changed from requiring that the application under this program be made within 48 months from discharge to a Vietnam Era veteran is one who served between the periods of August 5, 1964 and May 7, 1975.

PRIORITY NATIONAL SECURITY AND FOREIGN AFFAIRS PROGRAM

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Preamble

"We build, they build. We stop; they build."

> *–Secretary of Defense Harold Brown*
> *Speaking of the relentless Soviet military buildup*

"For the 31 months of its existence, the Carter Administration has presided over -- and has even taken credit for -- the greatest dismantling of American power -- spiritual as well as physical -- in our nation's modern history. . .

"Some mindless critics will, predictably, call us 'war mongers.'

"Nothing could be further from the truth.

"We neither conceived of, nor dissented from, the last four wars. We did our duty-- and we salute especially the more than one half million of our members who stood fast in Vietnam when self-important people in this country, who should have known better, counselled dissent, disobedience, draft-dodging and desertion.

"But, just being for peace isn't enough. Peace must and will be safe-guarded and under-girded with American power.

"My comrades, my charge to you to be 'IN FRONT OF THE REST' applies with special meaning to our beloved country in our foreign policy.

"We intend to help those who fight for American security and veterans' entitlements in the Congress and we will oppose and expose those who don't.

"We in the V.F.W. are 'IN FRONT OF THE REST' and we're going to stay that way."

--From acceptance remarks of
Howard E. Vander Clute, Jr.
National Commander-in-Chief
Veterans of Foreign Wars of the U.S.

WHERE WE STAND TODAY

The United States of America today faces the most profound threat of the 203 years of our history as a free society.

The external threat -- imperfectly perceived by far too many; denied or derided by others -- is, of course the Soviet Union and the expanding, global, politico-military power that this totalitarian society commands.

The response of this Administration has been a blend of bland disbelief, inexplicable inaction, or half measures, reluctantly adopted, too little and too late.

The security "guts" of Resolution 314 "Expose the Anti-Veteran and Anti-Defense Bias of the Carter Administration," passed unanimously at the National Convention, tells it-like-it-has-been-and-like-it-is:

"President Carter's consistent anti-defense bias is revealed by the following pattern of self-maiming actions:

"the total amnesty extended on 21 January 1977 - President Carter's first full day in office -- to America's moral lepers -- the draft dodgers;

"the shocking acceptance of a U. S. Navy sized, at 398 ships, far below the 900-plus vessels of the Soviet Union;

"the Presidential veto of the fifth nuclear carrier;

"the inexplicable Presidential curtailment of the B-1 bomber program without even seeking a quid pro quo from the Russians;

"the betrayal of our loyal ally, the Repub- of China on Taiwan;

"the planned (and partially completed) withdrawal of the Second Infantry Division from Korea – currently held in abeyance;

"the show boat firing of Major General Singlaub for being right about the nature of the communist threat in Korea;

"the inability of this Administration to keep either Iran or Nicaragua on our side;

"an African policy which favors Soviet-supplied and supported terrorist movements over evolutionary change in Zimbabwe-Rhodesia and Namibia-Southwest Africa;

"a low level of American civil defense which boarders on blind negligence;

"the blind refusal to bolster the sagging 'All Volunteer Forces' with a fully functioning draft for the reserves and registration and classification for America's young people;

"the shelving of the promising Enhanced Radiation/Reduced Blast neutron warhead as a timely counter to Soviet tank superiority in Europe;

"the supine acceptance of the introduction of Soviet MIG 23s into Cuba which fact violated the 1962 Kennedy-Krushchev agreement;

"the inexplicable decision not only to give away the Canal and the Canal Zone, but to pay Panamanian dictator Torrijos to accept this $20 billion U.S. investment;

"the gutless plan to recall veterans and retirees rather than conscript the young for a future emergency;

"a weird 'human rights' policy which is ignored by the communists while it devides and dismays many of our imperfect allies; and

"a proposed SALT II Treaty with the Soviet Union which would lock America into an irreversible position of strategic inferiority."

To the above litany of retreat and defeat, now add the unapologetic presence of a Soviet ground combat brigade in "Fortress Cuba."

If the foregoing tells-it-like-it-has-been-and-like-it-is, we are pledged in our Chief's word to be "IN FRONT OF THE REST" and to stay that way.

Here follows Key Security Goals -- designed with but one purpose in mind: To get America back where she belongs: IN FRONT OF THE REST.

Some of these Goals can reasonably be accomplished during the life of the 96th Congress. Others are a long-term commitment to achieve a better and safer America.

Security Goals For 1980

1. At the very core of our 1980 Security Program, we continue to stand for freedom and against communism and we will use every opportunity to press home this responsible and moral view to the president, the Executive Branch, and the 96th Congress.

2. We will call for eight per cent (8%) of our gross national product to be dedicated to revitalizing our sagging defense budget -- rather than the 4.9% of the gross national product in the current budget.

3. We call upon the President and the Congress to continue the present policy of no trade with Communist Cuba, and the policy of no diplomatic recognition of that communist state for as long as it remains the policy of that Cuban communist regime to retain the many harsh injustices now extant in that unfortunate land and have their armed forces serve under the strategic direction of the Soviet Union.

Further, under no circumstances should concessions be granted which will affect our complete and undiluted control and use of Guantanamo Bay as a U. S. Naval Base of supreme strategic, as well as political, importance.

4. We will redouble our efforts to assure that: (a) the autonomous Selective Service System be fully supported by the Office of Management and Budget as a key part of the total manpower mobilization effort; (b) annual registration of 18-year-olds be resumed as soon as feasible; (c) a headquarters, adequate to the foregoing, be re-established in each state of the Union, as well as at the national level; and (d) annual conscription of up to 200,000 men for the Army's individual ready reserve be instituted as soon as practicable.

5. We will do all in our collective power to

defeat the proposed SALT II accommodation with the Soviet Union.

6. As a matter of strategic urgency, we must press forward now with the development and full deployment of the cruise missile -- land, sea, and air -- as a badly overdue enhancement of the TRIAD (Bombers, ICBMs and SLBMs).

7. We will inform the President and members of the Congress that the number one strategic task confronting the United States now is to fund, build, equip and man a U. S. Navy which is clearly Number One.

8. We will call on the Administration, the State Department and the Congress to assure the territorial integrity of the Republic of China. Also, we urge the Administration and the Congress to allow the government of the Republic of China on Taiwan to purchase modern equipment and technology from the United States to successfully defend itself from any major aggression.

9. The United States shall withdraw no additional ground combat elements from the Republic of Korea and will maintain our ground combat forces in the Republic of Korea until a peace treaty has been signed between the two Koreas. Also, the United States must continue to provide the Republic of Korea with such military aid and assistance, including modernized military equipment, to enable her to safeguard her freedom, sustain her development, and promote stability in the Far East.

10. The Veterans of Foreign Wars of the United States will inform the President and Congress that our organization will support a fair and comprehensive U. S. energy policy designed to reverse growing U. S. dependence on OPEC oil imports and the concomitant mortgaging of our national security and freedom of action.

11. We will convey to the President and to Members of Congress our solid conviction

that the current policy of neglect towards the 20 nations of Latin America, save retreat on the Canal Zone, acceptance of Marxist revolutionary change in Nicaragua, and admonitions about "human rights," is bankrupt and that a new and discriminating pattern of nation to nation policies be undertaken as a matter of urgency.

THE V.F.W. IS AHEAD OF THE REST

FY 1980 LEGISLATIVE RECOMMENDATIONS OF VETERANS' ORGANIZATIONS

THURSDAY, MARCH 27, 1980

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 9 o'clock a.m., in room 1202, Dirksen Senate Office Building, Hon. Alan Cranston (chairman of the committee) presiding.

Present: Chairman Alan Cranston (presiding), Senators Strom Thurmond, Alan Simpson, and Howard M. Metzenbaum.

OPENING STATEMENT OF HON. ALAN CRANSTON, CHAIRMAN OF SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman CRANSTON. The hearing will please come to order.

Good morning, I want to extend a welcome to each and all of you. I want to thank you for coming this morning to submit legislative recommendations on behalf of your five respective veterans' organizations.

I would also like to express my sincere appreciation to you for altering your schedules to accommodate the time change of the hearing, which, unfortunately, was made necessary by a last minute change in the Senate's schedule. We have some important work that is going to be starting on the floor this morning.

I have made available copies of my prepared remarks and in the interest of time I will not read them in full. But, there is one matter of concern to all of us that I want to mention: The effect of the President's Federal hiring freeze on the VA. Before the hire-one-for-each-two-vacanies freeze was imposed, I wrote the President strongly urging that any Federal employment freeze must provide flexibility for the VA health-care system, and I described some of the devastating impacts—still besetting the system—of the fourth quarter 1978 freeze on VA medical facilities.

I am pleased to report that last Friday the Department of Medicine and Surgery notified all VA health-care facilities that they would have the flexibility they need under the freeze to maintain the quality of care provided to their veteran patients. We will be monitoring this situation very closely to assure that it works out the way it is supposed to, and I am glad that this effort of mine with the administration has borne this fruit.

Let me say also, as always, the recommendations you make this morning and, of course, the full text of your proposals will be closely studied by the members of the committee and will be given full consideration as we proceed with our legislative program for this 2d session of the 96th Congress. I look forward to hearing your presentations.

[The prepared statement of Chairman Cranston follows:]

PREPARED STATEMENT OF HON. ALAN CRANSTON, CHAIRMAN OF SENATE COMMITTEE ON VETERANS' AFFAIRS

Good morning. I want to extend to each and all of you a warm welcome and to thank you for coming this morning to submit legislative recommendations on behalf of your five respective veterans' organizations.

I would also like to express my sincere appreciation to you for altering your schedules to accommodate the time change of the hearing, which, unfortunately, was made necessary by a last minute change in the Senate's schedule.

As always, the recommendations you make this morning and, of course, the full text of your proposals will be closely studied by the members of the Committee and will be given full consideration as we proceed with our legislative program for this 2d session of the 96th Congress.

In connection with this Committee's program for this session, I would like to stress briefly a few of my commitments. First, I remain firmly committed to a strong, independent VA health-care system. Thus, I am totally opposed to the inclusion of the Veterans' Administration hospital and medical system in any national health insurance program to receive reimbursement from funding sources regulated by another agency for the non-service-connected care that the VA would render to veterans. That is the approach in President Carter's proposed "National Health Plan Act", S. 1812, and it is a bad idea. I intend to oppose that approach as hard as I personally can.

If such a reimbursement policy is adopted, it would make the VA dependent on funding from agencies whose priorities are other than meeting the health-care needs of the Nation's veterans. It would turn the VA into a middleman operating between insurance companies, regulated by another agency, and veterans needing health care.

Second, with regard to the fiscal year 1981 budget for the VA, I believe there is a broad consensus in the Congress and in the country that it is imperative to bring the Federal budget for fiscal year 1981 into balance as one of a number of steps that need to be taken to put the brakes on the inflation that is making life so difficult for all Americans, including our 30 million veterans, their 58 million family members, and the 3.6 million survivors of deceased veterans. As Majority Whip and Chairman of this Committee, I participated throughout the discussion over ten full days between Administration representatives and Congressional leaders to try to resolve the many issues that needed to be addressed. As a result of these unprecedented discussions, I believe that the prospects for a balanced budget are good and that a balanced budget is indispensable to our overall efforts to break the fever of inflation and restore health to our economy.

As important as the effort to balance the budget is, however, I am totally opposed to any reductions in veterans' programs that would, in any way, result in breaking our commitments to our Nation's veterans. Thus, in the discussions with the Administration regarding veterans' programs there were four principles that I held paramount and which, I believe, were all vindicated in the budget agreements reached and which I recommended to the Committee regarding the VA budget.

First, because the need to control inflation is so great, the VA must be a part of a Federal Government belt-tightening effort with respect to various administrative expenditures—such as acquisition of supplies and equipment and office expenses—and construction, but such belt-tightening must be a part of a Government-wide effort to hold down comparable spending in all agencies.

Second, there must be no reduction in the VA's personnel ceiling.

Third, there must be no closing of VA facilities and no reduction in the levels of services and assistance to which veterans and other VA beneficiaries are entitled under existing law.

Fourth, the consideration of new, priority legislative initiatives must not be foreclosed.

I believe that we have been successful in adhering to each of these principles; and it is clear to me that the President will not ask the VA to bear a disproportionate part of the burden of reductions in Federal spending. The budget amendments will not entail any reductions in VA health-care personnel; no VA offices or medical facilities will be closed; and the levels of services and assistance to which veterans are entitled will not be reduced. In addition the Administration will continue its support for four legislative initiatives; a full cost-of-living increase for disability compensation programs; a 10-percent increase in GI Bill benefits; a targeted delimiting date extension designed to benefit educationally disadvantaged and unemployed Vietnam-era veterans; and reform of the VA's vocational rehabilitation program for service-connected disabled veterans.

Likewise, the budget that this Committee recommended on March 18 includes provision for legislation reflecting comparable policies in those same areas, plus improvements in the VA's OJT program and legislation to update, improve, and make permanent, the VA's physician and dentist special-pay program and otherwise assist in the recruitment and retention of VA health-care personnel, and to make minor improvements in the VA's specially-adapted housing grant program.

The budget cuts that this Committee recommended totaled $298 million in spending proposed in the President's January budget for fiscal year 1981. I certainly wish that none of those cuts were necessary. But I sincerely believe that they are and that, together with other revisions in the Federal budget to eliminate the fiscal year 1981 deficit, they are truly in the best interests of the American people, veterans and nonveterans alike. I would also note that these reductions are about 60 percent less than those that were initially considered as options for VA programs and which would have resulted in substantial VA health-care personnel reductions and the closing of numerous health-care facilities. Any such cuts would be devastating and were and are totally unacceptable to me and, I know, this Committee.

Let me add a word on another budget-related issue of concern to all of us: the effect of the President's Federal hiring freeze on the VA. Before the hire-one-for-each-two-vacancies freeze was imposed, I wrote the President strongly urging that any Federal employment freeze must provide flexibility for the VA health-care system and describing some of the devastating impacts—still besetting the system—of the fourth-quarter 1978 freeze on VA medical facilities. I am pleased to report that last Friday the Department of Medicine and Surgery notified all VA health-care facilities that they would have the flexibility they need under the freeze to maintain the quality of care provided to their veteran patients. We will be monitoring this situation very closely to assure that it works out the way it's supposed to.

On another matter of particular importance, I introduced on February 19 legislation to make a comprehensive improvement, expansion, and modernization of the VA's rehabilitation programs for service-connected disabled veterans under chapter 31 of title 38. The Committee held a lengthy hearing on this legislation, and received valuable testimony from many of the veterans' organizations present today.

It has been 6 years since this Committee first called for a comprehensive revision of chapter 31, in light of the great changes that have occurred since 1943 in rehabilitation concepts and in the roles of seriously handicapped individuals in our society. Thus, I am extremely pleased that we are moving forward with this vitally important legislation, with a markup scheduled next Wednesday.

I also want to assure you of my support for a realistic cost-of-living increase in the rates of compensation and dependency and indemnity compensation benefits and for legislation to provide a permanent system of bonus pay for VA physicians and dentists in order to enhance recruitment and retention, and to improve the general employment provisions for VA nurses—a service which, in many regions, is experiencing both shortfalls in filling approved positions and high turnover rates—and other allied health personnel. The Committee plans, on April 16, to hold hearings on this legislation, which I will introduce shortly, and to meet to consider it on April 30.

These are a few of the highlights of this Committee's agenda for action during this session. Several other items are discussed in the Committee's budget report, copies of which are being mailed to your offices, and I hope that you will have the opportunity to review it closely.

We obviously have great challenges ahead of us this year—challenges we cannot possibly meet separately, but, together, as always, we shall prevail.

I now look foward to hearing your legislative goals and priorities.

Chairman CRANSTON. In the interest of time, you should abbreviate the full statement that will take any substantial amount of time, so we have time to hear the witnesses before the Senate schedule intervenes.

Thank you very much. We now proceed with our first witness, George W. Fowler, national commander, Veterans of World War I of the United States of America, Inc.

TESTIMONY OF GEORGE W. FOWLER, NATIONAL COMMANDER, VETERANS OF WORLD WAR I OF THE UNITED STATES OF AMERICA, INC., ACCOMPANIED BY FRANCIS P. GUIDERA, MICHAEL DOHERTY, AND FRANK PEACE, MEMBERS FROM THE STATE OF NEW YORK

Chairman CRANSTON. I am delighted to have you with us.

Commander FOWLER. Chairman Cranston and members of the committee, I want to apologize for being late. Our cab driver got lost.

Chairman CRANSTON. You weren't very late.

Commander FOWLER. I would like to take the time to introduce the members from New York who came down at their expense to bring their thoughts and to back me up.

On my right is Francis P. Guidera from New York.

Chairman CRANSTON. Happy to have you with us.

Commander FOWLER. Also, Michael Doherty and Frank Peace. I didn't think a New Yorker would ever get lost in Washington, but they did.

My name is George Fowler, national commander of the Veterans of World War I of the U.S.A., Inc., and as temporary chairman of our National Legislative Committee, I am presenting our legislative proposals for this session of the National Congress.

Our testimony will request three separate amendments to present pension laws and a renewed request for a World War I service pension to meet our needs which become more urgent every day.

We ask for the following amendments to Public Law 95-588:

That section 106 of the act, section 521, subsection (g) of title 38, be amended to include the surviving spouse in the increase which is granted to veterans who were not provided the benefits under the GI bill of rights.

The maximum base, beginning June 1, 1979, for widows of World War I veterans, is $217.92 per month and no aged widow can survive on this amount even when in good health.

During the past several years, it has been my sad duty to present the burial flags to the destitute widows of buddies with the statement that a "grateful nation presents to you, the flag under which your husband, and our buddy, served, loved, and respected".

But today, the word "grateful" has a hollow ring and it is time to insist that a grateful nation owes more to a destitute widow of a veteran than the flag that has draped his casket.

Again, referring to Public Law 95-588, we request that the annual accounting of income required of veterans or the surviving spouses who have reached the age of 75 years or who are bedfast or housebound, blind, or paralyzed, be simplified in order that they may be advised of the requirements for the benefits and they may answer the question of eligibility with a "yes" or "no".

It is sadistic to require these aged and often bedfast pensioners, many of whom are no longer mentally or physically able to give a factual report, to be subjected to this annual inquisition when the rule of reason reveals that each year they are becoming more in need.

This request will add no cost to the Veterans' Administration and may actually save by eliminating much wasted time.

Referring to Public Law 96–151, which went into effect January 1, 1980, we are grateful to the Congress for the provision for outpatient care that was granted to the veterans of World War I and the Mexican border period. It helps provide care to meet a special need for these veterans.

However, there is another provision needed and to illustrate that need, I will cite two actual cases of members of my local barracks at Dodge City, Kans., who were taken to the VA hospital at Wichita, Kans., a distance of 160 miles, and both were returned in caskets within a period of 1 week. They were terminal cases and were taken from home because they had exhausted all resources for local care.

We ask that Public Law 96–151 be amended to provide that in case of emergency, all World War I patients be granted the right for treatment in their local hospitals.

For the past several years, the veterans of World War I have been seeking a service pension to partially repay them for the sacrifices they have made in the past.

Each year, as our numbers have become fewer and our needs have become greater because of the decreasing value of our fixed incomes, our request becomes more emphatic.

We will not burden you with a repetition of our case except to cite a report taken from the records of the Social Security Administration, to wit:

> A social security recipient who retired at age 65 in 1960, which would include most of the veterans of World War I, and who had earned the highest wages used in computing his retirement benefit, is now drawing $343.40 per month.
>
> By comparison, a retiree who retires in 1980 under like conditions, will have a monthly benefit of $572.

It is well to note that very few World War I veterans retired with the maximum benefit because to do so, they would have earned $4,200 each year for the years 1956 through 1958 and $4,800 during the year before retirement and very few were earning these sums during the years before inflation.

We are the forgotten veterans. The veterans of the Revoutionary War were given land grants by Congress. The veterans of the Civil War were given a homestead of 160 acres for 3 years' service. The Spanish American War veterans were granted a pension, which at that time, far exceeded in purchasing power any amount that has been requested by the veterans of World War I.

Our sons who served in World War II have received under provision of the GI Bill of Rights, a measure which we sponsored with ustifiable pride, many benefits including free education, business and housing loans, and these benefits will provide them with financial security in their years of retirement.

Members of the Committee, each year we have been told that no money is available. But each year, we have witnessed billions of emergency aid given to tinhorn dictators and fair weather friends who have deserted us at our time of need.

In the proposed 1981 Fiscal Year Budget of about $600 billion, here is the necessary one-fourth of 1 percent required to do justice o our veterans.

In the final analysis, it is only a matter of priority.

What we ask is about one-sixth of the proposed emergency fund for the President. It is less than 1 percent of the proposed amount for health and human services and will in most cases, relieve the load on these services.

It is about one-third of the amount proposed for the Space Administration and although we commend America for planting the flag on the moon, we contend that the Americans who raised the Stars and Stripes over the fortress of Metz in 1918, performed a more worthwhile service to our country and the world.

The rings of Saturn will be available for our investigation 1,500 years from today, in case we have the available funds. But, in 15 years, the needs of our aged veterans, if unheeded, will be only a few dark pages in our Nation's history.

The mandate given by our members at the last National Convention at Hot Springs, was a request for an unrestricted service pension of $150 per month for all surviving veterans or widows of veterans of World War I.

We ask your Committee to honor this request.

Time is running out. It is estimated that over 70,000 veterans of World War I will die during 1980; 192 each day; 8 every hour.

During this 2-hour hearing, 16 of our buddies will die and our studies show that 6 of these 16 will die in actual need of better food and/or better care.

We ask this committee to be just and merciful to these aged patriots and our hope is that you Members sitting in judgment today may look back on your decision with the same pride shown by that brash young Army of 1917 who went to the defense of democracy with the battle cry: "Heaven, Hell, or Hoboken", and the survivors returned to Hoboken, chanting: "We have paid our debt to Lafayette. Now, who on Earth do we owe yet?"

Chairman Cranston and members of the committee, we thank you for this opportunity to plead our case.

Chairman CRANSTON. Thank you very, very, much. We appreciate your testimony and your very heartfelt and sincere expression of concern for the veterans you are representing. Thank you very, very much.

I do not have any questions at this time, thank you.

Our next witness is James Durkin, commander, Military Order of the Purple Heart.

TESTIMONY OF JAMES DURKIN, NATIONAL COMMANDER, MILITARY ORDER OF THE PURPLE HEART, ACCOMPANIED BY FRANK A. ATHANSON, NATIONAL ADJUTANT GENERAL; JERRY SEARLES, SENIOR VICE COMMANDER; RICHARD J. GALLANT, NATIONAL SERVICE DIRECTOR; MAURICE LOIR, LEGISLATIVE DIRECTOR; AND MRS. BETH KUBLY, NATIONAL PRESIDENT LADIES AUXILIARY

Commander DURKIN. Mr. Chairman, to my immediate right is my National Adjutant General, Frank A. Athanson. To his right, my Senior Vice Commander, Jerry Searles. To my immediate left is Richard J. Gallant, my national service director, and Maurice Loir, my legislative director. I also have present my national president, Ladies Auxiliary, Mrs. Beth Kubly.

Thank you very much, Mr. Chairman.

Mr. Chairman, distinguished members of the Committee on Veterans' Affairs, it is not unusual for a man to go through life without having some significant honor bestowed on him. I consider myself very fortunate, indeed, that I will be able to look back on two significant events in my life that will be a source of pride.

That is, the honor bestowed on me by my fellow Purple Hearters when they elected me their National Commander, and, being allowed to come before you today to represent my unique organization, The Military Order of the Purple Heart.

I stress the word, unique, because it is the only veterans' organization made up exclusively of combat-wounded veterans.

In that aspect we are unique. But, I want to emphatically state that the uniqueness ends there. By that I mean, The Military Order of the Purple Heart stands shoulder to shoulder with all of the other great veterans' organizations of this country, striving for the same objectives and having the same goals.

The various veterans' organizations meet at different times and geographic locations. Each will have conventions during which resolutions will be developed which set forth their positions on various matters.

I feel certain that when one reviews the positions developed by these organizations, one will find a striking similarity of the results. This is the way it should be, for we are all concerned with the veteran and matters related thereto. We march to the same drums and toward the same objectives. There should be no doubt in anyone's mind on this point. Because we are veterans, we tend to think the same way and have the same concerns.

The very fact that the membership of the various organizations willingly donate their time and personal funds for a common cause would indicate that this is a group of people who put extra special value on patriotism and the safety of our Nation.

Mr. Chairman, The Military Order of the Purple Heart has presented its legislative positions to your Committee in writing. For the sake of brevity, I will not repeat all of these positions at this time.

I would, however, like to take this opportunity to highlight two of our deepest concerns. One is related to the domestic area and the other to our international position.

This is not to say that our interest and concerns are limited to only one facet in each of these areas. But, rather it is our way of focusing on our key concerns; the veteran and our defense posture.

First, on the domestic front, the most burning issue for us now is the contemplated cuts in the Veterans' Administration budget. We are gravely concerned by the tone of the fiscal year 1981 budget. Even before it was enacted, the Administration has shown its apparent disregard for the veteran by preparing a several hundred million dollar reduction in its already austere recommendation for the VA.

This is a direct attack on the veteran. This budget will not provide the quality care that a grateful nation has mandated for its veterans; nor do we believe the Congress of the United States will accept such a proposal.

To allow this travesty to occur will, in effect, say to all veterans and future defenders of our freedoms, "The Congress of the United States has no respect for your sacrifices and will not speak nor act forthrightly on matters concerning veterans."

In the face of even more adversity than exists today, the majority of the Congress has stood by the veteran and we believe they will once again stand up and be counted, by their demanding that no budgetary cuts be made to the VA, and that they will no longer allow the continual deterioration of quality care and service to the veteran.

Turning to the international front, our grave concern is with the deteriorating international status of our Nation caused mainly by our weakening defense posture and thus our capacity to deter aggressive moves by the Soviet Union.

Recent events have created an awareness of the serious deterioration of the combat capabilities of our Nation's Armed Forces that has been going on for some time. We believe that strengthening of our Armed Forces can be achieved only by a national resolve to embark on a crash program to develop and produce sufficient quantities of modern weapons systems that are superior to systems being employed by the Soviet forces and, more importantly, to provide adequate numbers of quality personnel to man these systems.

Both of these actions take time to accomplish before significant results can be achieved. Although we are late in starting, every effort must be made to shorten the time required to achieve these goals.

With adequate funding, positive short-term results can be achieved. The finding of new weapons systems, however, will take much longer as is evidenced by the past performance of our research and development community. None of this can be accomplished with a defense budget that simply keeps up with inflation, nor have real impact without the proper quantity and quality of people.

Our organization feels strongly that the "all volunteer" concept is a political expedient whose time has passed and its continuance will serve only to further reduce the effectiveness of our Armed Forces. We must face reality and with resolve, seek alternatives.

Time is not on our side. We must act now, and with resolve, if we are to regain our position of strength and be able to deter aggressive actions on the part of the Soviets which may draw us into a confrontation or force us into further retreat.

Along with this, when we speak of our national defense posture, we must never forget that the VA medical facilities and staff have an integral role in these plans.

I realize fully that the two areas I have stressed come in direct conflict with the belt tightening that is presumably going on. I also realize that the pressure on Congress by various interest groups will intensify as cuts in the budget are made known.

We are in a way doing the same thing here today. But, we have no other choice. We view the VA budget with its latest proposed cuts as a reduction in total quality care of the veterans. Improvements to existing equipment, facilities, and construction of new facilities as being significantly curtailed.

Medical research that probably could find a way that would enable a veteran to be functional again may not happen. The direct loan program will be practically eliminated. Service to process claims and pensions will be seriously hampered with even more delays in processing. The Department of Medicine and Surgery relegated to a position of providing less than first-class medical service to our veterans.

This listing could go on for a long time. Let's stop it now. Let Congress show the same determination and steadfastness that made us veterans as they restore the VA to its rightful position of providing quality care and service to the veteran.

Mr. Chairman, we stand for the 30 million veterans and their families, and we stand for America. What better objectives could we have?

I want to thank you for giving us the opportunity to come before you and to respectfully request that our legislative positions we have submitted to you get your full consideration. Further, that our concern on the combat capability of our Armed Forces becomes an issue for you to focus on so that we will create a strong Nation and one where the Purple Hearters will fade away and no new members will be generated.

Finally, Mr. Chairman and members of the Veterans' Affairs Committee, we gratefully acknowledge your continuing efforts to provide meaningful legislation for veterans. Thank you.

Chairman CRANSTON. Thank you very much for your very thoughtful and heartfelt testimony, as with your predecessor at the microphone.

Thank you very much. I have no questions at this time.

[The prepared statement of Commander Durkin follows:]

Prepared Statement of James Durkin, National Commander, Military Order of the Purple Heart

LEGISLATIVE PROPOSALS

MARCH 27, 1980

MILITARY ORDER PURPLE HEART OF THE U.S.A.
1732
1932
1782

**THE ONLY CONGRESSIONALLY CHARTERED
VETERANS ORGANIZATION EXCLUSIVELY
For COMBAT WOUNDED VETERANS**

LEGISLATIVE PROPOSALS
MARCH 27, 1980

JAMES J. DURKIN, NATIONAL COMMANDER
MILITARY ORDER OF THE PURPLE HEART

The Military Order of the Purple Heart is very pleased to appear here today and to present our legislative objectives to this Committee. We would like to begin by pointing to the uniqueness of our organization. Our members are brought together by a single, common bond, the award of a medal. The Purple Heart medal was created by General George Washington in 1782, in recognition of military merit, thus it is America's oldest military decoration. Every one of our members served the United States in combat, and every one was wounded by an enemy of the United States. Naturally enough, our primary concerns are with those veterans who are disabled, those who are hospitalized, and those who are still trying to re-enter the mainstream of society. We earnestly hope that organizations like ours, born out of the suffering of war, will eventually cease to exist. Our legislative program is intended to reflect these concerns and we now offer our program to the Committee.

Our first concern is with the Veterans Administration. For more years than we care to count, the veterans organizations have been coming before this Committee to cite the inadequacies of the VA medical system; inadequacies created by the constant struggle over the budget. While the budget has grown considerably over the years, the rate of inflation is growing at a much faster rate. Inflationary pressures are seriously reducing the funds available for quality health care. Increasing demands for services are being met with staff shortages, long waiting periods, and reduced hospital bed levels. The situation is far worse for the veteran in need of domiciliary care and the proposed FY-81 budget only serves to aggravate an already serious problem. While Administrator Cleland makes many statements about the increased efficiency of the system, we find that quality health care is not achieved by playing a numbers game. We cannot gain more by simply investing less. We cannot have quality health care when we give the physician a greater workload. We must never place a physician in the position of having to decide which veteran is in greater need of care. The veteran's hospitals have been slowly deteriorating and the proposed budget will serve to speed up the process of decay. Immediate action by the Congress is needed to prevent any further erosion of the Veterans Administration health care system.

We feel that hospital affiliation with medical schools is generally beneficial to the veteran, but there are increasing instances where schools become dominant and the Dean's Committee makes too many of the decisions in regard to hiring, assignment, and transfer of VA physicians. It is our feeling that each hospital director must have absolute control over all personnel actions and policy matters in accordance with existing federal procedure. The role of the Dean's Committee should be only that of an advisory body.

A few of our concerns were met with passage of Public Law 96-151. The provisions concerning OMB and the World War I veterans did answer an important need. Since our organization is deeply concerned with the potential long tern effects that may arise from exposure to Agent Orange. We hope that the epidemiological study called for in P.L. 96-151 will supply some answers to this need as well. We ask that the Committee carefully and constantly monitor the progress of this study.

Several proposals for a national health care system have been introduced in the Congress. A few of these proposals include the VA hospitals as a basic part of the plan. The Military Order of the Purple Heart is unalterably opposed to any national health plan that includes the veterans' hosptials and clinics as a part of the plan. We will also oppose any attempt to use these facilities for the treatment of non-veterans, and we will oppose any attempt to merge any Veterans Administration program with the programs of any other agency of the government.

The subject of judicial review is indeed an important item. While our National Convention did not take a position of support, the Convention did reject a resolution of opposition. The consensus was to wait and to watch. This action was taken prior to Senate approval of a judicial review bill.

Veterans employment has been a nagging problem for some years. The many programs enacted to assist the unemployed veteran, while admirable in scope and objective, leave much to be desired in terms of execution and compliance. The local employment security agencies and the CETA prime sponsors often show little enthusiasm for veterans's programs. This results in limited achievement and further continuation of the problem. Without any incentive to perform well, a heavy responsibility falls on the Veterans Employment Service to properly monitor the various programs. The VES has had trouble meeting this responsibility because of staff limitations and shortages. A good example of this can be found in the New York City area. During most of 1979, the VES had two staff representatives to monitor seven CETA prime sponsors, and five HIRE II programs in an area containing a veteran population of 1.6 million. Needless to say, the area has a high unemployment rate for veterans. To avoid such staffing problems in the future, we propose that the VES staff be increased to allow for one representative for each 150,000 of the veteran population. This amounts to about a one-third increase for an already small staff. We further propose that each state have a minimum of two staff representatives. This would do much to insure more effective monitoring procedures. In addition, we ask that staff residency requirementsbe dropped. The only concern should be the ability to do the job, not how long the staffer has resided in a particular state.

The Disabled Veterans Outreach Program has proved to be of great help in serving veterans employment needs. We propose that the program be maintained at the original level of 2,000 aides until such time as the unemployment rate for the disabled veteran is roughly equal to that of his non-veteran counterpart.

The lack of enthusiasm mentioned earlier has led to mixed results for the HIRE II program. This leaves some unexpended funds. We ask that these funds be set aside for a similar purpose during FY-81.

The targeted jobs tax credit was expected to be of help in finding employment opportunities for the younger veteran. However, we find that many problems exist for the older veteran as well. These problems can be more severe since they are compounded by advancing age. To try to remedy this, we propose that the age limit be removed for TJTC eligibility as it applies to the veteran. We propose too, that the term "Vietnam era veteran" be replaced with "war service veteran." This might be of use to the older veteran who has been displaced from his job. It could offer some assistance before the veteran reaches the point of applying for SSI or general assistance and becoming eligible in those catagories. In addition, we find that TJTC is under utilized as it applies to the veteran. The reason for this could lie in the definition of the term "economically disadvantaged." To use Targeted Jobs Tax Credit, all applicants must have a family income of less than 70% of the Bureau of Labor Statistics lower income level. Between a veteran and his spouse, a part time job can mean ineligibility. Perhaps some relaxation of income standards is in order. One should not have to be completely destitute before receiving assistance.

As a last point on the subject of employment, we oppose any attempt to weaken or dilute veterans preference as defined in the Wagner-Peyser Act and subsequent legislation.

In looking at veterans benefits, we find that veterans may receive treatment for active psychosis with a two year presumptive period for service connection. However, since psychiatry is less than an exact science, it is probable that a veteran can stabilize for a period of years and suddenly collapse because of a particular situation. We support eliminating any presumptive period and consider instead the veteran's history and situation in determining service connection. Perhaps too, it might be more suitable to identify these cases as post traumatic stress disorders.

The intended improvements of Public Law 95-588 seem to have created more confusion than improvement in the pension program. One provision establishes an income standard that is intended to keep pensioners above the poverty level. However, the BLS income standards can differ significantly when applied to specific localities. In the more heavily populated areas, the BLS lower income level can be highter than the national average. Notwithstanding the principle of like benefits for like service, economic criteria does vary significantly with georgraphic location. This fact should be considered in determining the amount of pension entitlement. We ask too, that the 10% Social Security credit be restored along with the spouse exemption of $1,200, and that the earned income of the spouse continue to be exempted from the veteran's earned income.

In regard to dependent indemnity compensation, we propose that payment be made at the same percentage in cases where the veteran received compensation in excess of 60% for a period of ten years or more. This would apply regardless of the cause of death. In determining entitlement, we suggest that the spouse or survivor be allowed to maintain individual, rather than family income. Additionally, concurrent payment of survivor annuity and DIC should be allowed. We feel too, that no taxes should be levied in cases where the beneficiary is a non-resident alien.

Survivors of military retirees often face financial difficulties from payment of Social Security benefits that are based on the service of the retiree. Social Security benefits should not be allowed to offset a survivor annuity.

The military retiree who seeks federal employment and elects a combined military-civil service annuity, should be allowed to receive any Social Security entitlement due without any reduction in the CSA annuity. To a lesser extent this affects every veteran with service after 1956. Social Security entitlement should not affect CSA annuities.

In regard to CHAMPUS, we ask that the ceiling be increased to 90%, and that special efforts be made to attract more health care providers to the system.

Proposals have been made to do away with the present system of classification of discharge from military service. While we regret that poor service is often followed by permanent stigma, we feel that service should be recognized according to merit. The existing system of discharge classification should be maintained. In line with this, we oppose full entitlement for veteran's benefits in cases where the discharge is upgraded under reduced standards.

We also oppose any simplification or lessening of citizenship standards for those who fled the country and renounced their birthright in opposition to the Vietnam hostilities. All such cases should be processed in accordance with existing immigration procedures.

Our organization is opposed to approval of SALT II because recent events have created an awareness of serious deterioration of the combat capabilities of our nation's Armed Forces that has been going on for some time. The Armed Forces must be strengthened, and this can only be achieved by a national resolve to embark on a program to develop and produce sufficient weapons systems and to provide adequate numbers of quality personnel to man these systems. Both of these actions will take time before any significant results can be achieved. Although we are late in starting, every effort must be made to shorten the time required to achieve these goals. Positive short term results can be achieved. The fielding of new weapons systems will take much longer as is evidenced by the past performance of the research and development community. Adequate funding and new procedures are necessary to shorten the development cycle. This cannot be done with a defense budget that simply keeps up with inflation, nor can it be accomplished with the quality and quantity of people provided by the "all volunteer" concept.

As an organization of combat wounded veterans, we have intimately experienced the suffering of war. While we would like to see disarmament become an accomplished fact, we must face reality and proceed immediately to registration. If and when Selective Service starts it should be limited to those numbers needed to keep our armed forces at peak strength. No exemptions should be allowed except for those who voluntarily join our regular or reserve forces. We strongly feel that the "all volunteer" concept is a political expedient whose time has passed. Its continuence is only serving to further reduce the effectiveness of our Armed Forces.

Time is no longer on our side. We must act now and with resolve if we are to regain our position of strength and be able to deter actions on the part of other nations which may draw us into a confrontation or force us into further retreat.

As a final point, it appears that it is becoming possibe for German war criminals to escape prosecution due to the passage of time. The West German government is considering action to extend the statute of limitations for these crimes against humanity. It is our feeling that no statute of limitations should exist for these crimes. We ask that the United States take the proper diplomatic steps to support our position and to so inform the West German government.

This completes our presentation. We appreciate the opportunity to present our feelings and opinions to the Committee and we will be glad to make ourselves available for any further clarification.

Thank you, Mr. Chairman, and distinguished members of the Veterans Affairs Committee for this opportunity to present to you our legislative proposals.

Chairman CRANSTON. Our next witness is Joseph Koralewski, National Commander of AMVETS.

I would appreciate it if you would introduce formally for our hearing the people with you. I recognize Gabriel Brinsky and Leon Sanchez, but I don't know the name of the lady seated with you.

TESTIMONY OF JOSEPH R. KORALEWSKI, NATIONAL COMMANDER, AMVETS, ACCOMPANIED BY GABRIEL P. BRINSKY, NATIONAL LEGISLATIVE DIRECTOR; LEON SANCHEZ, NATIONAL EXECUTIVE DIRECTOR; AND MRS. LILA BASIGER, PRESIDENT, NATIONAL AUXILIARY

Commander KORALEWSKI. I would like to introduce our national legislative director, Gabriel P. Brinsky and our national executive director, Leon Sanchez, and to my far right, Mrs. Lila Basiger, president, National Auxiliary.

Chairman CRANSTON. Delighted to have you.

Commander KORALEWSKI. Mr. Chairman, we have a list of our legislative goals which will direct our activities during the coming year before the 2d session of the 96th Congress. My oral testimony and presentation will only highlight our legislative aims and I request that the appended list be accepted for the record.

I would like at this time to express the deep appreciation of AMVETS for the outstanding job done by the chairman and members of this committee on behalf of our Nation's veterans. And, I would like to single out specifically the committee staff who have been most helpful and cooperative. It is only with their guidance and help that the AMVETS has been able to be as effective as it has.

Under the medical care program, the Administrator of Veterans' Affairs and officials of the agency have uttered repeated assurances that the quality of the health care program will not suffer from the reductions which have been imposed during fiscal year 1980.

They cite the advances made in medicine which have resulted in a decrease in bed occupancy time. In spite of the additional funds Congress made available in the fiscal year 1979, thousands of hospital beds were closed down and the staffing of the department of medicine and surgery of the Veterans' Administration was curtailed by more than 6,000 people.

While undoubtedly some medical advances have been made, we cannot accept the claim that the quality or the extent of the services had not been affected. We continue to receive a constant stream of complaints from veterans who feel that they are not being accorded the medical treatment that is necessary.

We are appreciative of Congress' action in providing additional funds for fiscal year 1980 to restore 3,800 personnel in the department of medicine and surgery.

Some months ago, DM&S allocated these positions to the hospitals. Unfortunately, the directors of the hospitals were expected to find the funds necessary to help meet the cost of the salary increases which became effective October 1979. The authorization of additional personnel cannot be realized without funding needed to place them on the rolls. Authorization alone, therefore, becomes a vacant gesture.

More than 34,000 beds have been removed from the Veterans' Administration medical inpatient health care system since World War II. Granted that some losses were justified for varied legitimate considerations. Yet, many beds were closed as a part of a systematized, planned reduction program in the veterans health care services.

This in spite of the fact that the veteran population has doubled since that of World War II and it still continues to grow. The average age of the veteran continues to increase. Their medical needs are much more acute and the demands are greater because of the nature of their ailments. And, obviously, the frequency of their occurrences. If the present trend continues, the VA will be unable to fulfill its commitment of providing health care to our veterans.

As it is, veterans are now being turned away for the lack of facilities. If the present establishment is not able to take care of the needy veterans how can the system be expected to accommodate the ever-increasing veteran population and the increased demand?

Because of the advancing age of our veterans, AMVETS has a special interest in the VA geriatric and gerontological studies currently being pursued. We have been encouraged by the approach being taken by the Veterans' Administration.

We energetically support these activities which apparently go beyond the mere need for this type of treatment and is expanded into the area of how it may best be accomplished.

Under pension, the Veterans' and Survivors' Pension Improvement Act of 1978, Public Law 95–588, has not been well received by many veterans.

Their disappointment stems, in part, from the elimination of exclusions previously provided for in the prior law. But to a great extent, a substantial amount of dissatisfaction may be attributed to a previously created erroneous impression that the new law would provide for across-the-board rate increases. Had this expectation not prevailed, it is questionable whether the veteran population would have reacted as it had.

Of course, we recognize that the Pension Act has been in effect for a short period, Realistically, some imperfections can reasonably be expected. With time, they will surface.

As they do, we hope to exercise the privilege of bringing them to the attention of the committee. In the interim, we will be grateful if the committee would direct its attention to certain areas of the law which appeared to us to warrant immediate attention. And that is the area of the rates set for dependents. In our opinion, they seem to warrant revision upward.

The AMVETS, as expressed by a mandate of our 1979 convention, believes that a special pension program is indicated for our veterans of World War I.

While we do not believe in splintering veterans into various categories, we are of the firm conviction that this is an exception. The average age of the World War I veteran is 83 years. Their needs, as a part of the veterans' population, are special. And as a group, they are special in the eyes of patriotic Americans. Their contribution to the Nation will never be forgotten.

Education and training is an area for immediate attention in the GI Bill because of the need for an increase in the educational assistance allowance which is currently being paid to our veterans. While other benefits have been adjusted to assist in meeting the rise and the continuing cost of living, educational benefits have remained static since October of 1977.

We enthusiastically endorse legislation which is currently pending before the Congress which would provide for a 15-percent increase in the educational allowance. S. 87, GI Bill Amendments Act of 1979, and a 17-percent increase under chapter 31 in House passed H.R. 5288.

Regarding chapter 31 benefits, we are gratified to see that the Veterans' Administration once again is resuming its leadership in this field. As mandated by Public Law 95-202, the Veterans' Administration completed an exhaustive study on the vocational rehabilitation program. We agree with the VA that a redefinition of vocational rehabilitation is necessary.

We also believe that the maximum period permitted for rehabilitation and the time frame in which it may be pursued is too restrictive. It appears to us that a delimiting date defeats the purpose of vocational rehabilitation because it ignores the fact of continuing need.

I have addressed myself more specifically to the problem in the appended statement which I am submitting for the record.

White House Conference on Veterans Act: AMVETS favors H.R. 6486, a bill proposing a White House Conference on Veterans. Under the bill, a series of local and State conferences over a 3-year period would culminate in a White House funded national conference.

This would serve to bring all veterans together to map out the future of the veteran movement. We believe that the interests of veterans are equal to those of other groups, which have received Federal funding for White House conferences.

Judicial review: AMVETS favors a limited form of judicial review such as proposed under S. 330, as amended. Under this bill, decisions of the Board of Veterans' Appeals will be subject to review by a district Federal court.

The review would be limited as to the findings of the Administration pertaining to the subject matter of any arbitrary, capricious actions, or abuse of discretion, or otherwise not in accordance with the laws.

We believe that veterans should be entitled to have their day in court. Even though section 211 of title 38, United States Code, provides that decisions by the Administrator are final and not subject to judicial review, some courts have been assuming jurisdiction.

The repeal of section 211 would, in effect, make court review available to everyone rather than on a happen-chance basis.

I would like to conclude my remarks by again expressing my appreciation on behalf of AMVETS for your dedication and your efforts on behalf of our veterans.

We realize that there are those who would erode, if not completely eliminate, veterans benefits. Thanks to your vigilance and devotion, the veterans of this Nation may rest assured that they are being fully represented through the great Congress of the United States of America.

Thank you, Mr. Chairman, and members of the committee for the courtesies extended to me and my staff.

Chairman CRANSTON. Thank you very much for your very important testimony. We are delighted to have it.

[The prepared statement of Commander Koralewski follows:]

PREPARED STATEMENT OF JOSEPH R. KOBALEWSKI, NATIONAL COMMANDER, AMERICAN VETERANS OF WORLD WAR II—KOREA-VIET NAM (AMVETS)

VA MEDICAL CARE PROGRAM

We continue to be greatly concerned at the inroads being made on the VA Medical Care Program. More than 3,000 beds have been closed and thousands have been removed from the rolls of the Department of Medicine and Surgery. This, at a time, when the veteran population is increasing and is getting older. This, at a time, when the chronic and acute medical needs of the veteran because of severity of their service-connected disabilities are increasing with age. Instead of increasing the number of beds, increasing personnel, reductions are being made in both. Since the end of World War II until the last fiscal year, more than 34,000 beds have been removed from the Veterans Administration system. Yet, during the same period, the veteran population has doubled in number. In addition, the average age of the veteran has increased to the point where medical attention is required more frequently. None of this makes sense, unless it is the intention of the Administration to phase out veterans' medical health care programs.

And this has been attempted by various legislation which has been introduced in the last Congress. A current proposal pending before Congress would provide for reimbursement to the Veterans Administration of benefits due on health insurance policies carried by veterans being treated in VA hospitals for nonservice-connected conditions.

Apart from addressing the legal complications and ramifications which would be involved in any such legislation, AMVETS is opposed to the third party reimbursement on the basis that it would prostitute the entire concept of the veterans' medical health care program.

Apart from the legal issues which this principle of reimbursing third parties may involve, which we leave to the legal community, it could be the first step in the door towards the eventual elimination of the veterans' Health Care Program as we know it today. Congress in its generosity provided this benefit to veterans, a benefit which we view as being the most important of them all. The administration of the veterans' Health Care Program by the Veterans Administration has been proven to be the most cost affective of any endeavor and has no peer in the civilian sector. It is for these reasons that we are strongly opposed to the concept of third party reimbursement.

We are gratified by the passage of Public Law 96-151 which provides for medical services to World War veterans on the same basis which is currently being provided to the Spanish American War veterans except for the matter of dental treatment. We thank this Committee for the roll it played in bringing about this very important legislation.

COMPENSATION AND DIC

We are extremely appreciative that the Congress, through the efforts of this Committee, recognized the need for increasing the service-connected benefits paid to veterans and their dependents. Although the adjustment did not equal the CPI index, we are hopeful that in the future the Committee will address itself to the need for additional increase in order to meet and equate the escalation in the cost of living.

We are vehemently opposed to any legislation which would corrode the requirement to honest and faithful performance of military service for entitlement to veterans' benefits. Therefore, we oppose S-1041, which would eliminate the bar establishing the requirement that a service person cannot be AWOL for 180 days.

We strongly believe that veterans' benefits have been reserved for those who served. And only those who had performed their military service faithfully and honestly have really served. The national interest must arise above all. A service person who was AWOL for 180 days, regardless of the reason, is not serving the national interest. To equate the service of such persons with that performed by the honorably discharged veteran is a mockery. It is our sincere wish that Congress will not favorably consider such legislation.

We reiterate our prior request that the VA Rating Schedule be amended to include the allowance of at least a ten per cent (10%) evaluation for all postoperative service-connected malignancies. The rationale behind this request is that although the residual disability is not physically disabling, the mental anguish created by the knowledge of suffering a malignancy warrants the assignment of at least a ten per cent (10%) rating.

Although not within its jurisdiction, it may be of general interest to the Committee to be apprised of what we consider to be an inequity in the issurance of Commissary Cards by the Department of Defense. Under DOD Regulations, a Commissary Card may be granted to a dependent of a veteran who died from a service-connected disability which was rated at one hundred per cent (100%) at the time of his death. If his disability was rated less than one hundred per cent (100%) at the time he died, even though the service-connected disability caused his death, his dependent is not entitled to a Commissary Card. In our view, as mandated by the National Convention, the cause of death should control and not the rating in effect at the time of his death. We were informed by the Department of Defense that a recommendation was forwarded to Congress on February 1, 1980, which would enable this category of dependents to obtain commissary and exchange privileges.

WHITE HOUSE CONFERENCE ON VETERANS

We wholeheartedly endorse HR 6486, a Bill proposing a White House conference on the needs and concerns of all veterans. Other interests have received millions in Federal funding for White House conferences. It is time that the veterans get together and map out the future veteran movement.

The Bill envisions a series of local and state conferences over a three-year period to culminate in a White House funded national conference.

THE ADMINISTRATOR OF VETERANS AFFAIRS

The Administrator of Veterans Affairs is a Presidential Appointee- As such, he must follow the Administration's line and is precluded from exercising independent judgment which would result in a variation of the adopted policy. The Administrator should be the veterans' advocate and free to clash with the Administration where the interests of the veteran are concerned. This is difficult if not impossible since he serves at the President's pleasure.

AMVETS believe a solution to this problem is to have Veterans Administration Administrators appointed for a specified term, perhaps renewable six-year terms. In this manner, with looser political ties to the President, the Administrator would be free to exercise the leadership required in the veterans' behalf.

VIETNAM VETERANS

Public Law 96-22, was a step in the right direction in assisting the Vietnam veteran to readjust to civilian life. There are other areas of concern which affect these veterans. There is Agent Orange, Ionization radiation, and rehabilitation.

As regards Agent Orange, AMVETS believes that this matter should be resolved as expeditiously as possible. While there is presently no evidence, according to scientific data, that Agent Orange is responsible for a multitude of ills, except for chloracne, the Vietnam Era population is under tremendous mental discomfort on the subject. The Veterans Administration should resolve this issue as rapidly as possible in order to provide medical and compensation assistance should Agent Orange exposure result in disability. Even if the herbicide is found to be innocuous, unless the victim who has been exposed to it can be assured of this fact it can be damaging to his psychological well being.

As to the matter of vocational rehabilitation of the Vietnam veteran, this will be discussed under the heading of Vocational Rehabilitation.

By reason of convention mandate, we request Congress to set aside January 27 of each year as a special day of observance to duly recognize the Vietnam veteran. We recognize that other bills have been introduced in Congress to specially set aside a day to honor the Vietnam veterans. The fact that a day has been selected to do so rather than the specific date should be controlling.

EDUCATION AND TRAINING

The need for an increase in the educational Assistance Allowance under the GI Bill is a matter for immediate consideration. Other benefits have been readjusted to assist in meeting the esculating cost of living. The sole Veterans Administration benefit, educational assistance, has been left untouched since October 1977. We feel that the legislation currently pending in Congress which will provide for a 15 per cent increase is conservative. (S 870)

Regarding Chapter 31 benefits, we are gratified to see that the Veterans Administration once again has resumed the leadership in this area. As mandated by Public Law 95-202, the Veterans Administration has completed an exhaustive study on the Vocational Rehabilitation Program. We agree with the VA that a redefinition of vocational rehabilitation is necessary. We also believe that the maximum period permitted for rehabilitation and the time frame in which it may be pursued is too restrictive. It appears to us that a delimiting date defeats the purpose of Vocational Rehabilitation because it ignores the fact of continuing need.

In our opinion the study accomplished by the Veterans Administration was outstanding. It is thorough, objective, and analytical. The findings are informative and revealing. In general we embrace the recommendations made by the Veterans Administration in all its aspects. We believe that the Administrator should be complimented on a job well done.

In our opinion the more significant issue is its objective as defined under Title 38 U.S. Code, Chapter 31. Under the Chapter its avowed objective is to restore employability. The disabled veteran is considered rehabilitated when he is considered qualified for employment: That is, upon completion of training.

This definition, in our view, is entirely too narrow. Our goal should be more in keeping with the definition of the Rehabilitation Act of 1973, which considers that rehabilitation is not accomplished until the individual is placed in suitable employment and is maintained in that employment. Preferably, it should be in employment of his choice.

In addition to the need for redefining vocational rehabilitation as employed in Title 38, U.S. Code, Chapter 31, we feel that there are other areas of major concern to us which needs attention. We feel that the maximum period permitted for rehabilitation and the time frame within which it must be pursued are in need of readjustment.

Under Chapter 31, no course of vocational rehabilitation may exist beyond four years unless a longer period is prescribed by the Administrator. Basically, the extension may be granted by the director of a regional office when it is found that such is necessary because of the severity of the veteran's disability: or if it is determined that rehabilitation is an objective suitable in terms of the veteran's disability, interest, aptitudes and cannot be accomplished without exceeding 48 months: or if the veteran needs elementary or secondary education for entrance into a vocational course, in which case such a preparatory education up to 18 months followed by up to 48 months of vocational training, may be authorized.

In our opinion the criteria is too restrictive in limiting vocational rehabilitation to a suitable objective. Besides, the term "suitable objective" is extremely vague and nebulous. The controlling consideration in the extension of training beyond four years should be geared to the veteran's interests, motivation, activities, desires, and ambitions. Therefore, we urge removal of any general limit on training time, each case being described on its merits so as to enable the veteran to achieve his potential in employability.

Finally, we are of the view that there should be no delimiting date. Presently, under Chapter 31, there is a 9-year delimiting date which may be extended but only under certain circumstances including cases of seriously disabled veterans. As a result those veterans who are less than "seriously disabled" but who are in need of rehabilitation are denied. The delimiting date defeats the purpose of vocational rehabilitation, in our opinion, because it ignores the fact of continuing need. Furthermore, it fails to take into consideration the basic medical principle which is that diseases and injuries do not remain static. A disease or injury, noncompensably disabling, may at expiration of the delimiting date, increase in severity to the extent so as to qualify the veteran for vocational rehabilitation but who is denied because of the delimiting date.

JUDICIAL REVIEW

For many years, each new Session of Congress has considered the issue of judicial review of Veterans Administration decisions. Particularly has the Veterans Affairs Committee of the House of

Representatives conducted numerous hearings on this subject. During the past, as a whole, it has been the position of the National Service Organizations that judicial review was desirable. But with the evolution of legislation which ensured certain safeguards and provided certain procedures, some National Service Organizations have concluded that judicial review would serve no purpose. We are of the opinion, however, that to provide for judicial review, to give the veteran his day in court, is to provide him with an additional safeguard against capricious and unwarranted actions. We favor a limited form of judicial review such as is currently proposed under S-330 as amended. Under this Bill the decisions of the Board of Veterans Appeals will be subject to review by a District Federal Court only as to the findings of the Administrator as to whether they are arbitrary, capricious or are in abuse of discretion, or otherwise not in accordance with the laws.

We believe that this can only adhere to the benefit of the veteran. Even though Section 211 of Title 38 U.S. Code provides that decisions by the Administrator are final, some courts have been assuming jurisdiction. There is a lack of uniformity in the approach to these cases by the Federal Courts. Some refuse to accept jurisdiction which is in reality denied them by law. Repeal Law Section 211 would at least provide uniformity in the application of the law.

We realize that administrative law has its place in American jurisprudence. And, we do not wish to add to the already heavy burdens of the judiciary. However, we are of the conviction that providing for judicial review of the decisions of the Administrator of Veterans Affairs can only enhance the quality of adjudication involved in the adjudication of veterans benefits.

VETERANS EMPLOYMENT

Disappointment in the area of veterans' employment with the Department of Labor continues. We have witnessed a recurring history of "business as usual" as far as the veterans' population is concerned. We continue to believe that an Assistant Secretary of Labor for Veterans Employment is a prerequisite to an effective veteran employment program. We are completely in favor of HR 1816 and S 870 which would elevate the Assistant Secretary for Veterans Employment to a full Assistant Secretary. Such is necessary in order to assure ready access to the Secretary in order to expound the veterans' employment program. Without such an exposure, we are of the opinion that the anti-veteran bias as we perceive it in the Department of Labor will make ineffectual any viable veterans' program. It is imperative that an Assistant Secretary be in the position of over-seeing the veterans' employment programs. Although it has helped to have the position of Director, Veterans Employment Service reinstituted, which position is held by a professional, the position of Deputy Assistant Secretary for Veterans Employment is necessary in order to ensure access to the Secretary of Labor.

Convention resolutions call for additional funding for all phases of the veterans' employment service which includes job counseling, training and placement services for eligible veterans, and sufficient staffing in order to accomplish the objectives required by law.

We continue to be greatly concerned with the economic plight confronting many of our veterans who find themselves unemployed by reason of company relocations, absence of certain trade skills and a general economic deterioration. We have commented as to the actions which may be taken in rehabilitating those who are disabled by reason of service-connected disabilities, still the remaining veteran population should be provided for.

VETERANS PREFERENCE

By reason of attacks by various groups upon veterans preference, we are constrained to comment upon the subject. By convention mandate, and otherwise, we are unequivocally and vehemently opposed to any dilusion of veterans benefits. We view this as a contractual right between the Congress of the United States and the veterans who have served this country. A concerted effort is being made by women' groups and others who believe they are being discriminated against. Any benefit which is given to one and denied to another is discriminatory.

IONIZING RADIATION

During World War II and subsequently, the Department of Defense engaged in numerous nuclear explosions and studies. Many of the armed forces were exposed to the radiations of these explosions.

In the past, there has been much foot-dragging both by the Department of Defense and the Veterans Administration. The Department of Defense because of classification refused to make certain information available to the Veterans Administration. The latter, on its part refused to accept good secondary evidence establishing exposure and other factors necessary for a valid claim.

While the situation has improved, the Department of Defense having declassified numerous records pertaining to such tests, certain evidence continues to be difficult to obtain or is not readily available. The Veterans Administration, on its part, is not employing any liberality in its evaluation. We appreciate that certain guidelines have been adopted regarding the matter of the number of rems that the veteran may have been exposed to, it being accepted, where there is no evidence indicating otherwise, that he was exposed to the maximum which occurred at the time of the particular explosion. Nonetheless, there are other areas in which presumptions should be made in favor of the veteran. For example, where it cannot be medically established one way or the other whether the exposure to radiation was the cause of the cancer.

MUSTERING OUT PAY FOR VIETNAM VETERANS

By mandate of our National Convention in 1978, AMVETS had legislation introduced which would provide for mustering out pay to the Vietnam veterans. At our last Convention in August 1979, a similar mandate was given. It was the feeling of the Members that in all equity and good conscience, the Vietnam veteran should be given a mustering out pay as his fellow-soldiers received in World War II and other Conflicts.

THE DRAFT

Although this subject is not within the jurisdiction of this Committee, AMVETS would like to present its view on this most sensitive subject closely allied to veterans interest.

The volunteer Army which was begun in 1973 apparently has not been a success. The extent of two and one-half million men envisioned in 1970 did not reach reality. In fact, the present force is substantially below that. There are other problems such asthat of dependents stationed in Europe who would have to be evacuated in times of peril. And, there is a problem created by the fact that more than a third of the volunteers are leaving the Army without completing the first term of enlistment. Many object to the volunteer forces on a socio-economic basis. They point out that the Army is manned by Blacks and Hispanics at twice the proportion they bear to the overall population.

We realize that a universal draft is not popular. It is contrary to our heritage, both in concept and spirit. While most advanced nations in the world had drafts of their personnel for military service, the United States lead a sheltered existence because of its geographical location. Wars were fought on other lands and we entered the conflicts whenever we were ready to do so.

But the world is changed. We no longer are a sheltered Island. Our homes are no longer safe from the devastation of war. The world has grown smaller and our interests are different. The trouble spots are many and worldwide. If we are to fulfill our role as world leader, and more importantly protect our security, then our approach must adjust to the needs of the times.

The most effective way to protect our national interest is by draft of all physically eligible youth. Under such a plan, all male youth will be recruited following graduation from high school. Or in the case of drop-outs, at the age of 18 years. All would be required to serve for one year. There would be no exceptions.

In addition to providing for our conventional forces, additional benefits could accrue. Military training could enhance the overall physical conditioning of our youth. It could also provide educational opportunities by specialized training and in many cases it could improve the skills of the disenfranchised. The discipline provided by the military could help to improve the moral fiber of our youth.

CONCLUSIONS

AMVETS will continue to express interest and participate in any legislative matter pertaining to or affecting veterans. We will appreciate the opportunity to submit any oral or written testimony on any matter of concern to this or your Sub-Committees.

Chairman CRANSTON. We are very happy to have Senator Metzenbaum here today. He is here to say a few words, not of introduction, but of post comment.

Senator METZENBAUM. I particular wanted to come over to see you, and I am glad that you are here from our State. You are very respected in our community.

I see you are joined here today by Gabriel Brinsky, also a friend of mine, and you may be certain that your remarks will be taken into account by the Senate.

This committee is chaired by a great friend of the veterans and we work closely together, and I am happy to see you here this morning, and I welcome you.

Commander KORALEWSKI. Thank you very much.

Chairman CRANSTON. Senator Strom Thurmond, long a champion of veterans, and a member of this committee has a few words to say to you all.

Senator THURMOND. Thank you very much, Mr. Chairman.

I have four committee meetings to attend this morning, which will require me to run from one to another, but I did want to take time to be here with you for a few minutes.

I want to say that it is a pleasure to be here today and receive testimony from several veterans' organizations concerning their legislative recommendations for the second session of the 96th Congress.

Appearing today are representatives of the AMVETS, Veterans of World War I, Blinded Veterans Association, Paralyzed Veterans Association and the Military Order of the Purple Heart.

All of these organizations are fine organizations. I happen to be a member of several of them and I am proud of that membership.

I want to take this opportunity to welcome all of you here to Washington and commend you for the work that your organization is doing for the veterans of this Nation. If it were not for people like you there would not be a Capitol of this Nation. It is because you people fought for your country and sacrificed that you deserve every consideration possible.

The recommendations and observations that you make today will certainly help this committee in determining where our legislative priorities should be placed in the area of veterans benefits during this session of Congress.

Also, your testimony will be a reflection of the problems that your membership encounters in their day-to-day contacts with the Veterans' Administration. Each year I look forward to your appearance and have found that your testimony is of great assistance to this committee.

I believe we have from South Carolina, Mr. Bill O'Dell, the AMVETS' national service officer for South Carolina, in the audience today. I would like him to stand and be recognized.

Mr. O'Dell, we are glad to have you here.

If there are any other South Carolina AMVETS or other South Carolinians in the audience? If so, please stand.

I just want to say that I welcome all of you and we are delighted to have you with us, and feel sure that your testimony will be studied closely and receive every consideration.

Again, I want to say that our country owes a debt to its veterans that can never be repaid, and I shall always do what I can on behalf of our veterans population.

I have a statement here by Senator Robert T. Stafford who could not be here today due to his duties as the ranking minority member of the Senate Committee on Environment and Public Works. I now present that to you for the record, and thank you very much Mr. Chairman and I thank you for your courtesy.

Chairman CRANSTON. Thank you very much, Senator Thurmond. I thank you very much for your testimony, Mr. Koralewski.

[The prepared statement of Senator Stafford follows:]

PREPARED STATEMENT OF HON. ROBERT T. STAFFORD, A U.S. SENATOR FROM THE STATE OF VERMONT

Mr. Chairman, I join in welcoming all of you to our Senate Committee on Veterans' Affairs. We are pleased that the five organizations you represent are here to share with us your recommendations in behalf of America's veterans.

The officers and members of each of your organizatiaons have been most helpful to our Committee and to the Congress as we try to provide responsible and effective legislation in fulfilling our responsibilities to our Nation's veterans.

We do not have to remind any of you that this Committee needs the support of each of you and of the organizations you represent if we are to adequately meet the real needs of our veteran population. So we look forward to these annual presentations to guide us in our deliberations and to offer encouragement in our service to all veterans, and we thank you for the recommendations being offered today.

Chairman CRANSTON. Our next witness will be George E. Stocking, national president of the Blinded Veterans Association.

We are delighted to have you with us, and welcome you here.

TESTIMONY OF GEORGE E. STOCKING, NATIONAL PRESIDENT, BLINDED VETERANS ASSOCIATION, ACCOMPANIED BY SUMNER A. (TUT) VALE, ACTING EXECUTIVE DIRECTOR

Mr. STOCKING. Mr. Chairman, Members of the committee, it is, indeed, a privilege to have this opportunity to present the legislative presentation of the Blinded Veterans Association.

Chairman CRANSTON. May we please have order. Please proceed, thank you.

Mr. STOCKING. Thank you.

As I indicated, it is a privilege to be able to present the legislative program of the Blinded Veterans Association to your committee.

The timing is significant in that tomorrow, March 28, the Blinded Veterans Association will celebrate the 35th anniversary of its founding of the Old Farms Convalescent Hospital in Avon, Conn.

The BVA has had its ups and downs over the years, but I am proud to say that today the organization is stronger than ever. Our revitalized field service program and outreach employment program provide services for blinded veterans throughout the United States, helping them to achieve their personal, social, and vocational rehabilitation. Members of these staffs, with the exception of clerical workers, are all blinded veterans, and they work to provide this service to their brothers.

I would like to thank the committee on all the work it has done through the 1st session of the 96th Congress in providing needed veterans legislation in the areas of compensation, medical care, and increasing the staff of the Department of Medicine and Surgery.

The Blinded Veterans Association, like our brothers in the Paralyzed Veterans of America, have as our members individuals who are very seriously disabled. We are a small group, but our needs are major because of the severe disabilities that we have incurred. We would like to call this to the committee's attention, and to request certain legislative proposals. We would like to break our proposals down into four areas.

The first is the area of compensation and pension. The next is the area of dependents' services, the next is the area of blind rehabilitation services and medical care and finally, the area of home ownership.

Public Law 96-128 was passed indicating a 9.9 percent cost-of-living increase in compensation, the Blinded Veterans Association urges your committee and, through it, the Congress to pass legislation that would take into consideration the extreme increase in the cost of living during the last few months, and to remember that those veterans who are living on a fixed income have no other alternative but the legislation passed by Congress for providing the needed benefits for their livelihood.

There are certain areas relative to changes in the compensation schedule under section 314 which are in our testimony. We would appreciate your evaluating those areas where we feel that the Veterans' Administration's ratings are inadequate in relation to the severity of the disability of blindness.

One particular area is the combination of blindness with other disabilities, for example, hearing losses and amputations. The blinded veteran has as his main input of information his hearing. If this is impaired, even slightly, it makes a major reduction in his ability to function in his environment.

In addition, the loss of a hand or foot removes the tactile sensation that an individual gets and lessens his ability to follow through with his rehabilitation. We would appreciate your consideration in amending some of those areas.

In addition, the disability of blindness causes a great deal of need for aid and attendance, and we would appreciate consideration of extending the lower range of subsection (r) aid and attendance allowance to those blinded veterans who are presently rated under subsections (l), (m), and (n) under section 314.

There is another area in which we feel there is a major deficiency for single non-service-connected blinded veterans receiving pension and aid and attendance allowance. At the present time, if these individuals attend a blind rehab center, where the average length of training is approximately 18 weeks, they stand to lose part of their pension and all of their aid and attendance allowance after the period of 90 to 120 days. We feel this is a detriment, a discouragement, for rehabilitation.

The cost to the VA would be insignificant in changing this particular regulation. This is legislative in nature, and we feel Congress should look into it and consider changing this section.

We feel the veterans attending blind rehab centers are essentially trainees as opposed to being patients. However, the blind rehab centers are all located in medical facilities and therefore when the veteran is there, he is considered a patient. So his pension and aid and attendance allowance would be reduced for the length of time it takes to get through the program.

His costs at home—rent, mortgage payments, et cetera—often continue, because it would be impractical for him to eliminate his residency for the period of time that he is at a rehab center. We urge you to consider this.

In the area of dependents' services, we urge you to consider a change in the method of determining the rates of dependency and indemnity compensation. In 1978, the Veterans' Administration conducted a survey to determine the method of evaluating the rates for dependency and indemnity compensation. It was their report that it should continue being evaluated relative to the rank of the veteran.

We feel this decision is erroneous and that the veteran's standard of living is far more closely related to compensation.

The Blinded Veterans Association passed a resolution at the last convention requesting Congress to pass legislation changing the method of determining dependency and indemnity compensation so that it would be 50 percent of the veteran's compensation plus dependent allowance.

We feel this is a more realistic method of determining DIC benefits, particularly in the instance where it has often been 10, 20, 30, even 40 years since the veteran has been in service, and his rank on active duty is not really related to the standard of living he has achieved during the period subsequent to that time.

The Veterans' Administration has indicated that it might be difficult for them to offer two types of programs, one for the individual who died as a result of service, or shortly after service, and one as a result of the compensation rating. We feel that this doesn't hold water. The Veterans' Administration is presently running three pension programs, and I don't think they would have difficulty in running two DIC programs if that was a necessity.

In addition, we would urge the Senate to introduce a companion bill to H.R. 1806, relating to the chapter 35—survivors' and dependents' education assistance so that spouses of eligible veterans would have a different delimiting date than presently exists.

Often a veteran marries or remarries subsequent to his injury and therefore we feel that the delimiting date should start at the time of the marriage or remarriage rather than at the time of the occurrence of the disability.

Additionally, we request that you add to H.R. 1806 a section which would permit the delimiting date for the spouses of veterans who must take care of small preschool children to start at the time that these children become school age. This would be an appropriate benefit for those dependents.

In the area of oversight which the Veterans' Affairs Committee has for the Veterans' Administration, we would like to bring to your attention several items which may not be legislative, but are of deep concern to the Blinded Veterans Association. We have been frustrated in some instances in getting the Veterans' Administration to provide needed services for blinded veterans.

The Blind Rehab Program was established initially under the Army, as I mentioned, at the Old Avon Farms Army Convalescent Hospital because the VA did not accept the responsibility of providing blind rehabilitation training. It was not until 1948 after a great deal of pressure from the Blinded Veterans Association, and others, that the first Blind Rehab Center was first opened.

Several years later, in 1967, a second blind rehab center was opened because of the backlog of 100 blinded veterans waiting to go into the facilities. This was done at Palo Alto.

In 1969, another center was opened at Avon and at West Haven, Conn., to provide for the overload to another 100 blinded veterans. The same year, 1969, a southern blind rehab center was designated for Birmingham. It is now 1980 and this facility is not open.

We have 250 blinded veterans on the waiting list to get into the three existing centers, and it will be some time before the one in Birmingham is opened. We understand that the plan at present is for the facility to start construction and be opened in 1982. There is a tremendous need for this facility to be opened as soon as possible.

The Blinded Veterans Association contacted Congress in 1976 requesting that one be opened as soon as possible in temporary facilities. The Veterans' Administration has not followed through on this particular proposal, and no facility has been opened.

We feel strongly that there is a tremendous need for this type of operation, and we hope Congress will make sure that the facility that is presently planned will not be one of the ones cut by the Veterans' Administration.

I would urge you to consider opening—providing funds to open a temporary facility as soon as possible.

Another program that is of great importance to the Blinded Veterans Association is the program established in 1967 by the VA, called the Visual Impairment Service Program.

This is an operation which the VA has in various stations—76 medical facilities—to provide on-the-spot assistance to blinded veterans who are in need of assistance.

These individuals in a team composed of a social worker, psychologist, physician, ophthalmologist, audiologist, et cetera, provide the individual with services which are directed toward entry into the blind rehab centers.

Often because of the lack of slots open in the rehab centers, these people help the veterans get their rehab training from other sources. We feel the present situation with this VIS program is not functioning as well as it should be because of the understaffing. At the present time only six of the 76 stations have full-time coordinators. We would appreciate it if the budget would include that these 76 stations have at least one full-time coordinator in each facility.

Another area is training for prosthetic officers in order that they have the sensitivity to and understanding of the needs of the blinded veteran and of the type of equipment that is available. These areas are not necessarily legislative, but in your oversight capacity we would appreciate your consideration and contact with the Veterans' Administration about them.

Another area is homeownership. We have for some years passed resolutions requesting some type of low-interest-rate loans to 100-percent, service-connected veterans.

With the present situation of the impact of the President's request for a reduction in the budget, this may not be practical. However, we are concerned that because of the fixed income that seriously disabled veterans are functioning under their potential for providing their families with homes is very limited.

In Public Law 96-22, Congress requested the Veterans' Administration to do a study on the HISA, the home improvement and structural alteration situation for blinded veterans. The study was done and we feel it was rather inadequate.

We did a brief study similar to that and found the answers the VA got were not necessarily those that were available from blinded veterans.

We will present an individual report to the chairman and other members of the committee regarding this. We feel there is a need for some kind of assistance in home ownership and we request Congress assistance.

We would also request that you introduce into the Senate a companion to H.R. 6486, to provide for a White House Conference on Veterans. We feel that this is something that is needed and that would provide the input for the needs of blinded veterans and other veterans around the country.

Copies of the resolutions passed by the BVA at our last convention relating to congressional action are attached to our written testimony. We would appreciate your consideration of that, and we also have copies of H.R. 6486, and other things that are pertinent to that area.

We appreciate very much the opportunity to present this material to you, and thank you for the good work the committee has done.

Senator Cranston, we know that you have been a friend of the veteran and the Blinded Veterans Association would like to express its appreciation to you and the committee for those things that you have done for us and we would appreciate your taking consideration of those needs that we presently have.

Chairman CRANSTON. Thank you very, very much for your fine statement. You are speaking without anything to guide you except your deep convictions and your great experience.

[The prepared statement of President Stocking follows:]

BLINDED VETERANS ASSOCIATION
1735 DeSALES STREET, NORTHWEST • WASHINGTON, D. C. 20036 • (202) 347-4010

STATEMENT OF GEORGE E. STOCKING, ED.D
NATIONAL PRESIDENT BLINDED VETERANS ASSOCIATION
BEFORE
COMMITTEE ON VETERANS AFFAIRS
U. S. SENATE
MARCH 27, 1980

Thank you Mr. Chairman and Members of the Committee. It is a privilege to appear before you today to make the legislative presentation of the Blinded Veterans Association.

I am especially pleased to be here at this time because this Friday is the 35th anniversary of the day the BVA was founded at the Old Farms Convalescent Hospital in Avon, Connecticut. Over the years, the BVA has grown considerably and expanded its focus, but it remains dedicated to the principles upon which it was founded, which is summed up by our motto: "...that the blinded veteran may take his rightful place in the community of his fellows and work with them toward the creation of a peaceful world..."

Of course, the BVA has had its ups and downs in its 35 year history. But I'm proud to say that today the organization is stronger than ever. Our revitalized Field Service Program now has five representatives in locations throughout the country seeking out other blinded veterans and motivating them to seek rehabilitation as well as aiding them in obtaining federal benefits. Our Outreach Employment Program, now in its sixth year, has a strong record of assisting blinded veterans in getting

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employment and making potential employers aware of the capabilities of blinded veterans. Except for secretarial support, both of these programs are manned entirely by blinded veterans.

Before getting into specific legislative recommendations, I would like to briefly comment on the work of the 96th Congress to date. I am pleased that several bills concerning benefits for our nation's veterans became law during the first session of the 96th Congress. I would like to mention particularly Public Law 96-128, which provided for a 9.9% increase in Disability Compensation and Dependency and Indemnity Compensation Rates.

The BVA is, as I'm sure all of the nation's disabled veterans and their survivors are, grateful for this essential increase. However, as the Committee members are aware, the rate of inflation for the period covered by P.L. 96-128 was significantly greater than the rate of the increase provided for in the law.

I realize that the Committee does not work within a vacuum but within the restraints of tight fiscal policies and against a backdrop of an unpredictable economy. However, as I'm sure the Committee Members are aware, for the past two fiscal years, compensation and DIC rates have been eclipsed by rampaging inflation. I urge the Committee to push for an adequate increase in compensation payments for our nation's disabled veterans and their survivors in fiscal year 1981.

The BVA also supported the passage of the "Veterans' Health Care Amendments of 1979" (P.L. 96-22). These amendments provided many useful programs and needed benefits for veterans, but I would like to point out one in particular. Title I of the law extends eligibility for outpatient dental care benefits to veterans who have 100% service-connected disabilities, a provision that had been urged by BVA members at the last four conventions prior to 1979. Totally disabled veterans are the most economically disadvantaged of all veterans and the restoration of outpatient dental care benefits is a big step toward helping them to live adequately and comfortably.

The BVA is also pleased that P.L. 96-151 contains a provision requiring the Administration to set ceilings for health care personnel within the VA at the level for which appropriations are made by Congress. The BVA has been deeply concerned about the deterioration in recent years of the Veterans Administration hospital and health care system, and we hope that this law puts a halt to that trend. Of course, much vigilance is needed on the part of the Veterans Affairs Committees of the House and Senate and we urge the Committee Members to continue their effective oversight in this area.

As National President of the BVA, I would like to express the appreciation of our members for all of the hard work done by the Senate Veterans Affairs Committee during the first session of the 96th Congress on behalf of the nation's veterans.

DISABILITY RATING SCHEDULE

I would like to turn now to some specific legislative proposals. For the past several years, BVA convention delegates have passed resolutions concerning various aspects of the disability rating schedule as contained in Section 314 of Title 38 of the U.S. Code and the appropriate VA regulations. Basically, we believe that this schedule fails to adequately recognize certain differences in the type and degree of blindness among veterans and, therefore, certain inequities in compensation result.

Frankly, this has been a source of some frustration to us. It is sometimes difficult to determine even whose responsibility it is to make proposed changes, let alone persuading someone to act. Furthermore, we feel that there is a lack of appreciation for, and perhaps sensitivity to, the different types of blindness among veterans on the part of the VA.

Three different proposals are involved: Firstly, the schedule should be amended to give greater recognition to different degrees of impairment in field of vision. Secondly, the schedule should recognize that a veteran with loss of both visual acuity and visual field is more disabled than a person with the same degree loss of visual field only. Currently, the schedule makes no provision for rating the combined loss of visual acuity and visual fields. Thirdly, we believe that a veteran who is totally blind in both eyes, having no light perception, should be rated equally to a veteran with anatomical loss of the eyes or with eyes having deformity or scarring. Presently, the latter is rated more disabled than the former although it is possible that he has more vision than a veteran without light perception in either eye.

Copies of the resolutions setting forth these proposals in more detail are attached. I urge the Committee to consider these proposals carefully and to act on them.

A related and very deep concern of the BVA is the method of rating blindness in combination with other service-connected disabilities. For the past several years, BVA conventions have adopted resolutions urging Congress to pass legislation providing for increased compensation for blindness in combination with loss of hearing or the loss of a hand or foot.

The loss of tactile sense caused by an artificial hand or foot is considerably more handicapping when it occurs in combination with blindness since such loss deprives the veteran of essential contact with the environment.

Even more disturbing is the present method used by the VA in rating impaired hearing in combination with blindness. It would seem to be obvious that the sense of hearing becomes the principal avenue of information for a blinded veteran and that impaired hearing in combination with blindness compounds problems incident to the pursuit of vocational, social and recreational activities. Even minor hearing losses can affect a veteran's directional capabilities, thus seriously restricting his mobility in an unfamiliar area.

Currently, except for a few statutory provisions dealing with loss of hearing in combination with loss of sight, the Veterans Administration assigns percentages of disability for hearing loss occurring in blinded persons as if such hearing losses occurred in individuals with perfect vision.

The BVA has been working with the VA and with Congress for years to solve this problem, but we have been unsuccessful. The VA has indicated that the solution to the problem is a regulatory, rather than legislative, matter yet they have refused to follow up on our recommendations. Thus, we believe that legislative action is necessary.

I have attached to my testimony a copy of a bill that was introduced in 1974 that would revise the disability rating schedule so as to give sufficient recognition to the extra hardships imposed on a blinded veteran by hearing losses or amputations of extremities. I urge the Committee to introduce this legislation and to work towards its passage. We will be glad to work with you on this matter.

A final concern of the BVA with the disability rating schedule concerns the aid and attendance award for service-connected disabled veterans. We believe that blinded veterans rated under subsections (l),

(m) and (n) of Section 314 should be given the lower amount of aid and attendance as provided for under subsection (r).

The VA's rating schedule is based on economic loss and studies have shown that, as a group, the blind have experienced more difficulty in gaining employment and establishing income than the disabled population as a whole. There are many things that blind people need assistance with that are done by sighted people as a matter of course, such as bookkeeping, lawn mowing and car driving. Providing blinded veterans the lower tier aid and attendance would give them the means to have these necessary services done.

BLIND REHABILITATION CENTERS

The fundamental purpose of the Blinded Veterans Association is to aid blinded veterans in becoming self-reliant and productive members of society. In order to accomplish this goal, the BVA encourages blinded veterans to attend the VA's Blind Rehabilitation Centers (BRC's) and clinics where they can learn the skills they need to overcome their handicap. However, because of a quirk in the law, our Field Service Representatives find that they often have a problem in motivating individuals to take advantage of the resources offered by these agencies.

If a disabled veteran who is not married attends a BRC or clinic and he is receiving aid and attendance, his compensation payments may be reduced by that amount or if he is receiving a pension, that may be reduced. Because of this inequity, many of these veterans are not motivated to seek the rehabilitation and training they need to become financially independent.

The non-service-connected blinded veteran is especially hard hit because his already meager income from his pension may be cut even further during his stay in a BRC. He must continue to meet his rental or mortgage payments and other fixed expenses on a reduced income during the 18 weeks (and longer in clinics) that an average BRC program lasts. Many of these veterans decide that they simply cannot afford to do this, especially since they are not married and may not have any other sources of income.

Let me emphasize that this is a serious problem. With the unemployment rate among blinded veterans a staggeringly high 80%, it is axiomatic that we need to remove every roadblock that we possibly can standing between the veteran and his rehabilitation which he needs to have for his further vocational training and eventual employment.

I urge the Committee to amend Title 38 so that a blinded veteran may attend the VA blind rehabilitation centers and clinics without fear of financial loss while doing so.

Another area of concern to the BVA and to all blinded veterans relating to blind rehabilitation is the delay being experienced in the opening of a fourth blind rehabilitation center by the Veterans

Administration. Currently, the VA has three blind rehabilitation centers and three clinics, with a total capacity of 121 beds. Since the mid 1960's the BVA has been urging the opening of a fourth center in the southeastern U.S. in order to accommodate the backlog of blinded veterans needing rehabilitation. A decision was made in 1969 to establish a center in Birmingham. In 1975, plans were developed to open a temporary facility there. However, the Office of Management and Budget deleted the funds for this facility from the VA budget submission for FY 1978.

The BVA obtained support to replace the needed funds but a VA spokesman in the Department of Medicine and Surgery told a staff member of the House Appropriations Committee that the VA wanted a permanent center as opposed to a temporary center. The best that we were able to do, therefore, was to have $500,000 provided for the planning of the permanent center. The status of that planning is that the call for bids is scheduled to go out next month with bids to be opened on May 20th. Construction will begin shortly thereafter and is scheduled to be completed in the summer of 1982. The target date for entry of the first patient is September of 1982 -- 13 years after the decision was first made to have the blind center in Birmingham.

As of December 1979, there were 250 blinded veterans waiting to enter blind centers for their rehabilitation training. There are other blinded veterans who will not add their names to this list because of the long waiting period, which has been as much as over a year. One of the prime purposes of our Field Service Program is to motivate blinded veterans to enter a rehabilitation center. The delay in their being able to receive this much needed training, which will enable them to become active participating members of their communities and society as a whole, defeats our efforts and the efforts of the VA itself.

A blind center in the southeastern U.S. is urgently needed and it is needed now. I urge this Committee to take the necessary steps to provide for the opening of a temporary center until the permanent center is in operation.

DEPENDENCY AND INDEMNITY COMPENSATION

The BVA believes that the present rate schedule for the payment of Dependency and Indemnity Compensation benefits to surviving spouses is unfair and should be amended. These DIC rates are determined by the highest rank or grade held in the Armed Forces by the disabled spouse whereas disability compensation is paid in like amounts for like disabilities. It does not stand to reason that the surviving spouses of disabled veterans should be paid different amounts when those same veterans were paid equal amounts when they were still alive.

The present policy is based on the rationale that DIC is compensation for lost earnings, and that there is a correlation between military pay levels and levels of post-service earnings. Its supporters argue that it would be inequitable to ignore service pay grades in the DIC schedules because a veteran who served in a higher military pay grade has probably experienced a greater loss of potential earnings than a veteran who served in a low pay grade.

Simply put, we are not convinced that this argument holds water. From our experience, the previous military grade earned by a veteran and his financial status at the time of his death do not have a strong relationship, especially in instances where that service occurred 30 or 40 years earlier. Moreover, we believe that the greater inequity is that the survivors of two veterans, who are equal in all respects other than their former military pay grades, are treated unequally.

A much more equitable DIC rate would be to provide surviving spouses 50% of the deceased veterans compensation plus dependency allowance.

HOME OWNERSHIP

A long held concern of the BVA is the difficulty in establishing home ownership. In our present inflationary economy, the soaring cost of homes together with high interest rates have hurt all of us greatly, however the impact on severely disabled veterans, whose income and savings tend to be lower than the general population, is great indeed. Many of these veterans find it very difficult, if not impossible, to buy homes. Their difficulties are compounded by the fact that many savings and loan associations and banks will not make GI and FHA home loans.

Home ownership has long been an accepted goal of the American family and the BVA believes that the Veterans Administration has an obligation to assist 100% service-connected disabled veterans in obtaining home loans. Specifically, the BVA would like to see the establishment of a program of direct, low interest home loans to these veterans.

EDUCATION BENEFITS FOR SPOUSES

Another concern of BVA members for the past several years is with education benefits for spouses. Recently, legislation has passed Congress establishing the principle that an extension for the eligibility for education benefits should be granted to veterans, as well as to eligible survivors and dependents eligible under Chapter 35, equal to periods when these individuals incurred disabilities that precluded their entry into or completion of an education program.

The BVA believes that this principle should be extended to allow those spouses eligible for education benefits an extension of the ten year delimitation period equal to the time that they were caring for pre-school or disabled children or a disabled veteran. Individuals in such situations also are limited in their ability to utilize their entitlement to education benefits.

Similarly, we believe that, in the case of the veterans's remarriage, the period of eligibility should extend ten years from the date of such marriage. I am encouraged that legislation has been introduced in the

House which would allow for such an extension (H.R. 1806). I urge you to introduce the House bill into the Senate, Mr. Chairman, and to amend it to conform to our proposals.

WHITE HOUSE CONFERENCE

I am greatly encouraged that legislation has been introduced in the House on behalf of the BVA authorizing a White House Conference on Veterans (H.R. 6486). Under the proposed legislation, the Conference would be specifically charged with examining and reporting on critical problems being experienced by the nation's veterans, such as the delivery of quality medical care, education and employment services; provision of psychological and readjustment services; and efficient delivery of veterans assistance services and benefits by the various federal, state and local agencies.

This legislation would fulfill a pledge made by the Carter Administration but never carried out. A wide spectrum of veterans would participate heavily in the Conference, from the initial planning stages to the end result so as to ensure that a compassionate and balanced perspective is brought to bear upon the work of the Conference.

I would hope that the Committee would introduce this legislation and work for its passage. Of course, the BVA is willing to work closely with the Committee Members on this matter.

MEASURES REQUIRING VA ACTION

Before concluding my statement, I would like to briefly cover some recommendations that require action on the part of the Veterans Administration. I am bringing these matters to the attention of this Committee because we have not been successful in persuading the VA to take up our suggestions and, as our elected representatives with authority over the VA, I believe you should be aware of our concerns.

The VA is responsible for establishing regulations concerning service-connection of various eye disorders. Current VA regulations with regard to Retinitis Pigmentosa (RP) imply that the disease is in all cases hereditary, however the applicable medical literature, produced by opthalmologists, reveals that there are different forms of RP and not all of them are hereditary. We believe that the VA should distinguish between the different forms of RP in adjudicating whether a disability is service-connected. Even in cases where a veteran has a form of RP known to be of hereditary origin, that veteran's disability should be adjudicated by the VA in the same manner as are many other diseases of hereditary origin (for instance, diabetes and epilepsy).

The BVA has urged for years that the VA fund training programs for prosthetic chiefs and clerks so as to ensure that they are sensitive to the needs of blinded veterans and aware of technological advances. Experience has shown that VA personnel are often unfamiliar with the needs of blinded veterans and unaware of the availability of aids to meet these needs. As a result, blinded veterans sometimes go without prosthetic aids which they need and to which they are entitled.

The VA established Visual Impairment Service Teams in 1967 to provide needed services to blinded veterans. In our view, the performance of these teams has been largely ineffective and inconsistent due to staffing and funding problems. We feel that the VIS Teams could be improved considerably through prompt and positive action to provide direct VA Central Office funding for the positions of Secretary Coordinators of all remaining VIS Teams not already funded in such a manner. In addition, we believe that final authority for the selection, placement and changing of Secretary Coordinator positions should be given to the Chief of Blind Rehabilitation at the VA.

This concludes my legislative statement. I would like to thank the Members of the Committee for all of their work on behalf of the nation's veterans during the 96th Congress. Of course, it would be impossible for the BVA to accomplish its goals without the commitment and dedication of the Members of the Veterans Affairs Committee. I am confident you will continue to serve the interests of all veterans and I urge you to give careful consideration to the legislative recommendations that I have made here today.

I would be glad to answer any questions that the Committee Members may have.

RESOLUTION NO. 3/79

RESOLVED, that the Blinded Veterans Association, assembled in Los Angeles, California this 11th day of August, 1979 urge Congress to introduce legislation which would entitle veterans who have field defects which subtend an angular distance no greater than 15 degrees be rated 80%, that veterans whose widest diameter of visual field subtends an angular distance no greater than 10 degrees be rated 90%, and that those with a 9, 8, 7, or 6 degree defect be rated at 100%.

RESOLUTION NO. 4/79

WHEREAS, Title 38, U.S. Code, Section 314, contains inequities in the disability rating of veterans having total blindness without the anatomical loss of one or both eyes (sub-paragraph M), AND

WHEREAS, under this law it is possible that a man with light perception in one eye and total blindness or anatomical loss or scarring or deformity in the other eye (sub-paragraph M plus intermediate rates), would have a higher rating than a man who is totally blind in both eyes, AND

WHEREAS, this law is based on the presence of scarring and deformity, rather than on the loss of visual function, AND

WHEREAS, this presents an inequity for the man who is totally blind in both eyes without scarring or deformity, THEREFORE BE IT

RESOLVED, that the Blinded Veterans Association, in National Convention assembled in Los Angeles, California, August 11, 1979, supports legislation to change Title 38, U.S. Code, to provide that veterans who are totally blind be rated under sub-paragraph N to equate total blindness with anatomical loss of the eyes or with eyes having deformity or scarring.

RESOLUTION NO. 5/79

WHEREAS, Title 38, U.S. Code, in its treatment of visual disabilities makes no provision for rating the combined loss of visual acuity and visual fields, AND

WHEREAS, a veteran with a visual acuity of 20/200 and a 15 degree field is more disabled than a veteran with the same acuity and a normal degree field, AND

WHEREAS, the first veteran is 70% disabled for acuities and 70% disabled for field and the second veteran is 70% disabled for acuity only, THEREFORE BE IT

RESOLVED, by the Blinded Veterans Association in Convention assembled this 11th day of August, 1979, in Los Angeles, California, that the Congress be called upon to establish a more equitable disability rating system for veterans suffering both the loss of acuity and loss of visual field.

RESOLUTION NO. 6/79

WHEREAS, Proposed legislation to liberalize examinations and ratings for compensation for blinded veterans with additional service-connected disabilities, such as amputation or loss of hearing, has not been enacted into law, THEREFORE BE IT

RESOLVED, that the BVA continue to urge Congress to enact this proposed legislation into law at the earliest possible date.

RESOLUTION NO. 7/79

WHEREAS, the Veterans Administration rating schedule is based on economic loss, AND

WHEREAS, the last economic validation study by the VA showed that economic loss for blinded veterans was one of the most severe, AND

WHEREAS, study after study has shown that as a disability group the blind have experienced more difficulty in gaining employment and in establishing an income comparable to the average of the general work force, AND

WHEREAS, most paralyzed veterans receive more than $500 monthly more than most blinded veterans, AND

WHEREAS, non-service-connected blinded veterans with 5/200 vision or less receiving a pension are automatically entitled to aid and attendance, yet service-connected blinded veterans are not entitled to the additional Aid and Attendance Allowance under U.S. Code, Title 38, Section 314, subsection (r), AND

WHEREAS, many people think of aid and attendance strictly as medical care without thinking how aid and attendance could assist a blinded veteran as, for example, reading, bookkeeping, lawn mowing, research and other types of non-medical aid and attendance, AND

WHEREAS, the Canadian Government provides a special aid and attendance for blinded veterans, THEREFORE BE IT

RESOLVED, that service-connected blinded veterans rated under U.S. Code, Title 38, Section 314, subsections L, M, or N (less than 2,000 blinded veterans are in this category) be entitled to subsection (r) to make blinded veterans more fairly compensated.

RESOLUTION NO. 8/79

WHEREAS, home ownership has long been an accepted goal of the American family, AND

WHEREAS, in our present inflationary economy, the cost of homes has risen greatly, interest rates have become exorbitant, and discount policies at commercial lending institutions have combined to make home ownership for many 100% service-connected disabled veterans difficult, if not impossible, AND

WHEREAS, many Savings and Loan Associations and banks will not make GI and FHA home loans, THEREFORE BE IT

RESOLVED, that the Blinded Veterans Association in Convention assembled in Los Angeles, California the 11th day of August, 1979, does hereby urge Congress to pass legislation authorizing the Veterans Administration to make direct, low interest home loans to 100% service-connected disabled veterans. The amount of such loans should be sufficient to permit the veteran to purchase a home without resorting to borrowing from commercial lending institutions and should be limited in amount only by the veteran's ability to repay the loan.

RESOLUTION NO. 13/79

WHEREAS, the Visual Impairment Service was established in 1967 to provide much needed services to blinded veterans, AND

WHEREAS, because of staffing and funding problems, these services have not been provided to all eligible blinded veterans, or in equal proportions, AND

WHEREAS, the VIS Team Secretary Coordinator is a primary staff person who acts as a catalyst among the various disciplines, AND

WHEREAS, in all but several stations, VIS Team Secretary Coordinators have other responsibilities in addition to the VIS Teams, thus precluding the providing of needed services to all eligible blinded veterans, AND

WHEREAS, the quality and quantity of services are directly dependent upon the amount of time that the Secretary Coordinator has to devote to this assignment and upon that person's knowledge and motivation to provide the needed service, AND

WHEREAS, in some stations these services have been even further eroded by decisions made by supervisors regarding the selection, placement and changing of Secretary Coordinators, AND

WHEREAS, it is understood that direct funding from the Veterans Administration Central Office has been provided to such programs as: alcohol abuse, drug abuse, day treatment centers, spinal cord injury centers, etc..., AND

WHEREAS, better services could be provided to eligible blinded veterans if a similar approach was taken to the funding of VIS Teams. THEREFORE BE IT

RESOLVED, that the Blinded Veterans Association, in convention assembled in Los Angeles, California, August 11, 1979, hereby strongly urges the Veterans Administration to take prompt, positive action to provide direct Central Office funding for the positions of Secretary Coordinators of all remaining VIS Teams presently not so funded in the Veterans Administration system, AND BE IT FURTHER

RESOLVED, that the Chief of Blind Rehabilitation, Veterans Administration Central Office, be given final authority and responsibility for the selection, placement and changing of staff personnel filling the positions of VIS Team Secretary Coordinators.

RESOLUTION NO. 15/79

WHEREAS, blinded veterans are eligible to receive many different types of prosthetic and sensory aids, AND

WHEREAS, the complexity and variety of these aids and appliances is increasing greatly, due to rapid technological advances, AND

WHEREAS, experience has shown that many of the Chiefs of the various prosthetic services are unfamiliar with the needs of the blinded veterans and unaware of the availability of aids to meet these needs, THEREFORE BE IT

RESOLVED, that the BVA requests that the Veterans Administration provide funding for training of prosthetic chiefs and clerks so they will be sensitive to the specific needs of blinded veterans and aware of the technological advances which have been made, AND THEREFORE BE IT

FURTHER RESOLVED, that the prosthetic chiefs and clerks be provided with periodic reviews to keep their knowledge current.

RESOLUTION NO. 16/79

WHEREAS, Title 38, USC, Chapter 35 and other pertinent VA regulations and directives, establish a period of eligibility and entitlement for spouse, widow and widower of disabled veterans rated permanently and totally disabled, AND

WHEREAS, the VA regulations provide for a time period not to exceed ten (10) years from the date of veteran's eligibility, AND

WHEREAS, recent legislation has permitted an extension of this eligibility of widows, widowers and spouses, beyond this period when such individuals have incurred disabilities which have precluded their entry into, or completion of training, THEREFORE BE IT

RESOLVED, that the Blinded Veterans Association in Convention assembled in Los Angeles, California on August 11, 1979, urges the U.S. Congress to pass legislation extending the widows, widowers and spouses eligibility for a period equal to that during which the said individual was responsible for the care of pre-school or disabled children, or a disabled veteran, AND BE IT FURTHER

RESOLVED, that in the case of the veteran's remarriage, the period of eligibility shall extend ten (10) years from the date of such marriage.

RESOLUTION NO. 17/79

WHEREAS, the Blinded Veterans Association and its Representatives, urge all blinded veterans to attend the Rehabilitation Training Centers, and take advantage of all that is offered, to help them overcome the handicap of blindness, AND

WHEREAS, some blinded veterans are reluctant to go to these centers because of the loss of pension or reduction of compensation payments while they are in training, AND

WHEREAS, the veterans' expenses continue though they are not at home, THEREFORE BE IT

RESOLVED, that BVA National Headquarters be urged to take the necessary action to have the U.S. Congress change this rule, so that all blinded veterans will feel free to attend the Training Centers without fear of a financial loss while doing so.

RESOLUTION NO. 19/79

WHEREAS, we have studied and reviewed the medical problem identified by the Veterans Administration as Retinitis Pigmentosa and the Veterans Administration policy regarding veterans claims for disability benefits because of this disease, AND

WHEREAS, our study and review reveals that Retinitis Pigmentosa is only one of several disease entities identified under the prime classification of Pigmentary Retinal Degenerations; with sub-classifications of PRIMARY Retinitis Pigmentosa of hereditary origin; SECONDARY Retinitis Pigmentosa caused by retinotoxic drugs and/or inflammatory, infectious and viral diseases; as well as Choroidal Pigmentary Degeneration, AND

WHEREAS, the applicable medical literature, produced by competent and outstanding ophthalmologists, reveals that the subject of Retinitis Pigmentosa has caused a great deal of controversy; that the aetiology of Retinitis Pigmentosa is unknown; that the term Retinitis Pigmentosa is used indiscriminately, is a catchall phrase, is a misnomer and is considered to be the wastebasket of ophthalmology, AND

WHEREAS, the literature referred to above, reveals that Retinitis Pigmentosa may be hereditary, perhaps is hereditary, has a tendency to be hereditary, some times is hereditary, plus many comparable ambiguous expressions of terminology, to the total absense of any indication that Retinitis Pigmentosa IS of hereditary origin in ALL cases as implied by Veterans Administration Reg. M21-1 50.05 d, AND

WHEREAS, the Veterans Administration does not readily recognize those cases of SECONDARY Retinitis Pigmentosa because of the restrictive language of the above referred to VA Regulations, AND

WHEREAS, it is our considered opinion that service-connected disability compensation should be paid to those veterans infected with SECONDARY Retinitis Pigmentosa, AND

WHEREAS, it is further, our considered opinion that veterans claims for service-connected disability benefits because of PRIMARY Retinitis Pigmentosa should be adjudicated by the Veterans Administration pursuant to the provisions of VA Reg. 1309 (#3.309) DISEASES SUBJECT TO PRESUMPTIVE SERVICE CONNECTIONS as are many other diseases of hereditary origin, IE: diabetes, epilepsy, etc..., etc.AND

WHEREAS, "merely stating that a disease can be inherited is no actual evidence for its real origin, it is merely a description of a means of transmission." THEREFORE BE IT

Resolution No. 19/79 (Cont.)

RESOLVED, that the Blinded Veterans Association assembled in Convention at Los Angeles, California on August 11, 1979, urges the Veterans Administration to recognize that under the general term of Pigmentary Retinal Degenerations that there is Primary Retinitis Pigmentosa, and Secondary Retinitis Pigmentosa, and that there are differences between them as to origin, AND BE IT FURTHER

RESOLVED, that the Blinded Veterans Association urges the Veterans Administration to take the following specific actions relative to the below cited VA Regulations, in order to effect recognition of these differences:

No. 1. Re: VA M21-1 50.05 d. "The Eyes" - "Etiology"

> "Retinitis Pigmentosa, notwithstanding that the disease, and its effects, may not be known to the disabled person before (undertaking) military service, is regarded as of familial origin, thus existing prior to enlistment."

That the VA recognize the fallacy of its implied policy that ALL cases of retinitis pigmentosa are MANDATED to be of familial origin and that the VA adjudicate all such claims under the PRIME disease entity of PIGMENTARY RETINAL DEGENERATIONS with sub-classifications of:

a. PRIMARY RETINITIS PIGMENTOSA of familial origin. (Note (a) below).

b. SECONDARY RETINITIS PIGMENTOSA of toxic or inflammatory disease origin, and/or with possible choroid involvement. (Note (b) below).

NOTE (a). Available medical literature and professional opinion will support a determination that these cases will be readily minifested early in service and that other family cases may be readily determinable. These cases would NOT be Service-Connected.

NOTE (b). These cases to be considered for SERVICE CONNECTION on a totally individual basis, subject to an open and TOTAL evaluation of all available military and medical evidence.

No. 2. Re: VA M21-1 50.05 b (1). "Long established policy permits service connection with such unusual developments as choroidal degeneration."

That the VA direct Rating Board personnel to open their minds to the existence of this applicable VA regulation and to adopt a policy to consider the likelihood of choroidal involvement in cases of pigmentary retinal degeneration, and, further, that Rating Board personnel not discard competent professional evidence attesting to choroidal involvement.

Resolution No. 19/79 (Cont.)

No. 3. Re: VA Reg. 1309 (#3.309). "DISABILITIES SUBJECT TO PRESUMPTIVE SERVICE CONNECTION"

That the VA extend its implied policy, as indicated in the above referred to VA Regulation, that, "Because a disease MAY be inherited is NO evidence that it IS inherited", to include SECONDARY RETINITIS PIGMENTOSA, as is the policy for other inheritable diseases, notably, diabetes and epilepsy, plus many others.

RESOLUTION NO. 20/79

WHEREAS, the United States government has instituted a policy of arbitrarily reducing the size of Veterans Administration Hospital capacity to serve veterans regardless of the needs of the veterans. THEREFORE BE IT

RESOLVED, that the BVA should strongly recommend to the VA and all appropriate government officials that the VA should do everything in its power to get the hospitals fully staffed to accommodate all the medical and hospital needs of all eligible veterans and especially in the larger cities.

RESOLUTION NO. 27/79

WHEREAS, all totally and permanently disabled veterans receive like compensation for their like disabilities, AND

WHEREAS, there is no discrimination as to the rank or grade of the veterans while in the Armed Forces, AND

WHEREAS, D.I.C. rates are determined by the highest rank or grade held in the Armed Forces, which are discriminatory. It is unfair, that a surviving spouse of a blinded Captain should receive a higher rate of D.I.C. than the surviving spouse of a blinded Corporal, yet while they lived they (the veterans) were equally compensated for their blindness, NOW, THEREFORE BE IT

RESOLVED, that the members of the Blinded Veterans Association in convention in Los Angeles on August 11, 1979, do urge amending Title 38, U.S.C. by changing the DIC rate for a surviving spouse to 50% of the compensation paid to the deceased veteran plus dependency allowance, thereby eliminating any discrimination contained in the present law.

94th CONGRESS
2d Session

H. R. 13496

IN THE HOUSE OF REPRESENTATIVES

April 30, 1976

Mr. Teague (by request) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38 of the United States Code to provide increased awards of service-connected compensation to certain blinded veterans who are suffering from additional disabilities.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) subsection (o) of section 314 of title 38, United States Code is amended by striking out "60 per centum or more disabling" and inserting in lieu thereof the following: "20 per centum or more disabling, or the veteran has suffered service-connected total deafness in one ear, [~~or has suffered service-connected total deafness in one ear~~] or has suffered the anatomical loss or loss of use of hand or of a foot".

I

(b) subsection (p) of section 314 of title 38 United States Code is amended by striking out "In the event the veteran has suffered service-connected blindness with 5/200 visual acuity or less and (1) has also suffered bilateral deafness (and the hearing impairment in either one or both ears is service-connected) rated at no less than 40 per centum disabling, the Administrator shall allow the next higher rate, or (2) has also suffered service-connected total deafness in one ear, the Administrator shall allow the next intermediate rate, but in no event in excess of ~~$1,100,~~" $1,547

SEC. 2. This Act shall be effective the first day of the first month following the date of its enactment.

Chairman **Cranston**. We are going to have to recess temporarily before proceeding with the final witness, Paralyzed Veterans of America.

Senator Simpson will be here to proceed. I have to go elsewhere. Thank you very much. We will resume in just a moment.

I would like to note for the record that Tut Vale is also present.

[Whereupon, a short recess was taken.]

Senator **Simpson** [presiding]. The hearing will come to order. I do apologize for being late. I see the good chairman was called away, and I am Al Simpson, the ranking minority member of the Veterans' Affairs Committee.

I will take this opportunity briefly to thank the chairman of the committee for the opportunity of filling in for him, while he attends to other Senate business that demands his attention.

I know I speak for the entire committee when I say that no one in the U.S. Senate has done more for the needs of veterans than Senator Al Cranston. It has been a real privilege and a unique learning experience for me as a freshman Senator to be a ranking minority member of this committee.

I won't tell you how I happened into this unique situation in any detail. It has been a great privilege and learning experience to work with Al Cranston. I appreciate the personal courtesy and wise counsel that he has given to me.

I won't delay the proceedings further. It is not for me to speak, but for us to listen. But, I do appreciate all of you being here, and I appreciate also the public service of the distinquished veterans groups that are here represented, and I trust that in years to come we can all continue to work closely, as we have in the past, to shape effective legislation to meet the needs of the Nation's veterans.

This looks like a church service. Everybody is sitting in the back. I wish you would all move closer. I can hardly see you. Come forward, if you will.

I believe the next witnesses are Joseph Romagnano, national president of the Paralyzed Veterans of America, accompanied by Michael Delaney, senior vice president; R. Jack Powell, the executive director; and Gerald Jones, deputy executive director.

Please proceed with your testimony, and thank you.

TESTIMONY OF JOSEPH M. ROMAGNANO, NATIONAL PRESIDENT, PARALYZED VETERANS OF AMERICA, ACCOMPANIED BY MICHAEL DELANEY, SENIOR VICE PRESIDENT; R. JACK POWELL, EXECUTIVE DIRECTOR; AND GERALD JONES, DEPUTY EXECUTIVE DIRECTOR

Mr. **Romagnano**. Thank you, Senator Simpson. I realize my name is difficult to pronounce, but you did a good job.

Senator **Simpson**. I got it, didn't I?

Mr. **Romagnano**. I appreciate it, sir.

Mr. Chairman and distinguished members of the committee, it is a privilege to appear before you today to present the Legislative concerns of Paralyzed Veterans of America.

We would like to preface our testimony today by recognizing the continued service rendered by this Committee on behalf of America's veterans.

The leadership shown by the committee chairman, the Honorable Alan Cranston—I am sorry he is not here to hear this—combined with the dedication and wisdom of the members, are invaluable assets in meeting the needs of the men and women who have served this great Nation.

PVA is an organization of approximately 11,000 veterans who are members of 33 chapters located throughout the Nation, Puerto Rico, and Mexico. These members qualify for membership due to spinal cord injury or disease. Our membership is almost equally divided between service-connected disabled and non-service-connected disabled veterans.

Because of the time restraints faced by this committee and the need for other veterans' organizations to present their legislative suggestions, I will keep my comments brief.

However, I would like to submit for the record PVA's written statement in which we examine more fully some issues that are of paramount importance to us.

Senator SIMPSON. Without objection, that is so ordered.

Mr. ROMAGNANO. One of the most pressing issues to confront veterans is the administration's recently proposed budget cuts and veterans look to members of this committee to insure the future viability of a strong Veterans' Administration. The need for fiscal austerity and a balanced Federal budget are clearly important during this period of rapidly escalating inflation. It is also evident that all segments of America must act in a responsible and enlightened manner if these goals are to be met with the imposition of the least amount of hardship.

However, it must also be stressed that blind, haphazard cuts of existing programs can frequently only create hardships for those individuals most in need of assistance.

The cutting of programs predicated on mere expedience or because those affected appear to be politically impotent would be most injudicious and detrimental.

The specter of reductions in the budget of the Department of Medicine and Surgery (DM&S) is especially troubling to us because adequate and timely health care is PVA's first priority.

During the past several years there have been drastic reductions in personnel, beds, and funds available in the VA medical system.

To further erode the needed financing for this health care system is to undermine the viability and substance of commitments made to the Nation's veterans. The availability of medical services to veterans has already been diminished to an unprecedented low. Further diminution would be intolerable.

At a time when many veterans of World War II are beginning to place more demands on the VA hospital system, the contemplation of anything other than the strengthening of the system is most alarming.

The VA health care system must not be allowed to be reduced or even maintained at its present, inadequate level but must, instead, be upgraded and increased if the anticipated needs of veterans are to be served.

Another appalling example of the decline of the VA health care system is the increasing incidence of veterans in need of health care services being forced to wait undue periods of time, receiving inadequate or untimely care, or being deprived of care altogether.

We have received many complaints from many areas of the United States from our veteran population that this is happening. With this occurring simultaneously with the number of beds being reduced, the construction of needed facilities being deferred, and programs being inadequately implemented, it appears that the VA is slowly and insidiously being dismantled.

Despite these evident shortcomings, the present administration continues to insist that the quality of care has not suffered, and that the DM&S budget can be further reduced.

An example of the administration's disregard for congressional intent and its willingness to jeopardize veterans' health care for apparent savings is demonstrated in the fact that Public Law 96-151 gives the Department of Medicine and Surgery the authority to furnish nonprescription drugs, medicines, and supplies to eligible non-service-connected disabled veterans when these services are determined to be "reasonable or necessary".

The Office of Management and Budget has applied an excessively restrictive interpretation to this provision, and, rather than viewing it as a means of providing eligible veterans with needed health care items, it proposed denying these benefits in order to save the Government $10 million.

PVA feels that such actions violate the intent of Congress and that these miniscule savings are at the expense of those veterans who are most in need.

PVA must stress in addressing the needs of the VA health care system, that our primary focus is on the maintenance and improvement of the spinal cord injury service.

One area of concern is the level of staff turnover that comes from low morale and associated problems inherent to the spinal cord injury service.

All levels of staff at SCI facilities must contend with the problems common to all of the Department of Medicine and Surgery plus the physical demands associated with mobility-impaired patients and the psychological difficulty that comes from dealing, on a daily basis, with institutionalized patients.

Long-term and sustaining care frequently provide little opportunity for professional interaction with colleagues and fewer opportunities to practice in fields of specialization.

In the Veterans' Administration's recently published "Spinal Cord Injury Program Fiscal Year 1980-1987," it was recommended that the three distinct categories of spinal cord injury care—intensive rehabilitation, sustaining care, and long-term—be separated and be carried out at separate facilities.

PVA must assert that this proposal will lead to increased problems of recruitment and retention of qualified health care personnel and, will have a deleterious effect on the care for veterans who have experienced spinal cord injury or disease.

An alternative which PVA hopes this committee will consider is the colocation of domiciliaries with specified existing spinal cord injury centers.

The advantage of this proposal, as opposed to that of the VA, are several. First, the patient mix afforded by such a system would help in alleviating the morale problems of the SCI staffs that exist in the present system, and that would be perpetuated and aggravated by the Veterans' Administration's proposal.

Patients institutionalized at such domiciliaries would thereby be insured of receiving adequate and immediate treatment from health care specialists who are familiar with the complications associated with spinal cord injury and disease.

Finally, under the VA's proposal, veterans would be required to seek care at centers which might be located at great distances from their homes and families. And, family members are so vital to the veteran's ultimate return to a full and productive life.

During the 1st session of the 96th Congress, this committee did not hesitate to reconsider the rate of increase for compensation when it became evident that the rate of inflation was exceeding what was originally anticipated. PVA gratefully acknowledges this concern for veterans' needs.

It has become obvious that an improved method of computing compensation benefits must be employed if the standard of living for the most severely disabled veterans is not to decline.

During the past 3 years the rates of increase in compensation have increasingly fallen below the rates of inflation in the December to December Consumer Price Index (CPI).

This means that, even with these increases in the compensation rates, many severely disabled veterans have suffered a real decline in their financial well-being.

In order to meet this dual problem of escalating inflation and declining relative compensation rates, PVA suggests that for those veterans who are rated 70 percent or more disabled because of service-connected disabilities, the annual increase in compensation payments should be indexed to the CPI.

According to the VA's statistics of June 1979, fewer than 12 percent of all veterans in receipt of compensation were rated at 70-percent or greater disability. Therefore, this relatively small number of service-connected severely disabled veterans could be compensated in this manner for their drastically reduced capability without excessive costs to the Government.

Congress also continued to recognize the Naiton's debt to non-service-connected disabled veterans who, likewise, gave of themselves during times of war.

We request that this committee give prompt consideration to H.R. 5951, a bill introduced at PVA's request which would amend title 38 to provide an incentive for severely disabled veterans who are in receipt of pension to live outside an institutional setting.

This bill would increase the aid and attendance (A&A) allowance to a level that would enable the individual to live independently.

PVA must emphasize the need for a significant increase in the aid and attendance allowance for non-service-connected veterans. Such an increase is of great importance if the recently established pension program is to fully meet the needs of those it was designed to assist.

It should be noted that it costs approximately twice as much to maintain an individual in a hospital as it does in an institution such as a nursing home, but it would cost less than half of this latter amount per individual per month if the provisions of H.R.

5951 became law and the veteran lives independent of the institutional setting.

At this time of increasing fiscal restraint this factor should certainly be considered. Additionally, we trust that the Members of this Committee will recognize that the quality of life is more fulfilling for most individuals, whenever possible, if they live independently.

Mr. Chairman, in PVA's written testimony you will find considerable attention given to the problems faced by surviving spouses of veterans. PVA recognizes that millions of World War II Veterans are approaching 60 years of age, and it is vitally important that Congress promptly pass legislation that will help care for the surviving spouses of those who suffered severe disabilities in service to the Nation.

I will mention here very briefly what we see as some necessary steps to take in meeting the needs of these spouses.

First, the disability and indemnity compensation program offered under title 38 should be revised so that survivors of service-connected disabled veterans will receive benefits based on the degree of disability, not on the veteran's military pay grade.

Benefits for a surviving spouse should be at least 75 percent of the disabled veterans' monthly compensation rate at the time of death.

Second, the National Service Life Insurance (NSLI) program needs to be amended if the security of disabled veterans and their families is to be maintained.

Frequently the disabled veteran, due to his reduced earning capacity and his inability to secure private life insurance, is unable to accumulate an estate adequate for the needs of his surviving spouse and dependents.

PVA recommends that the maximum allowable limit for NSLI be increased from $10,000 to $50,000. This increased amount, more realistic in terms of today's rapidly escalating living costs, would provide the veteran with the knowledge that his survivors would be cared for after his death. It should be noted that the maximum allowable limit for national service life insurance has not been increased since the 92d Congress.

PVA is very concerned over the well-being of veterans' families, and we feel that the members of this committee will agree with us that these individuals must not suffer because of service rendered to the Nation by the individual veteran.

Furthermore, we want to see the VA maintain an adequate health care system capable of serving the Nation's veterans and capable of rendering essential service in the event of national involvement in further military activities.

Finally, income-maintenance for service-connected disabled veterans must keep abreast of inflation and all disabled veterans must be encouraged and allowed to live independent, satisfying lives whenever possible. As mentioned, earlier, each of these points is developed more fully in PVA's written statement.

Mr. Chairman and members of the committee, as national president, and on behalf of the members of Paralyzed Veterans of America, I thank you and your extremely capable staff for the cooperation and consideration which you have shown our organization.

We look forward to working with you in the future and to presenting in detail these and other issues which are of concern to America's veterans. PVA sincerely appreciates your allowing us to express here today our needs, views, and concerns. Thank you, sir.

Senator SIMPSON. Thank you very much, Mr. Romagnano. We appreciate your being here. I assure you that the committee will consider the things that you have expressed to us, and it is helpful having your testimony.

I think you are certainly correct in your reference to the staff of this committee. The staff of this committee is very capable and very interested and genuinely so.

I think the legislation that comes out of the committee reflects that.

Thank you so much for your time and effort in appearing here to present your legislative recommendations. I look forward to working with you as I have in the past, and working for you too.

As the Chairman has pointed out so adroitly, it is a year of budgetary restraint and caution in the land. There is no question about that, and certainly a year of oversight for the Congress to perform, and there is no question about that.

It is a difficult mission, but I am sure the committee will meet it. So, thank you very much for being here.

Mr. ROMAGNANO. Thank you, sir.

Senator SIMPSON. I think the other witnesses have testified, and, therefore, at this point we will conclude the proceedings today. We now stand adjourned. Thank you all very much.

[Whereupon, at 10:15 a.m., the hearing was adjourned.]

[The prepared statement of President Romagnano follows:]

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PVA
PARALYZED
VETERANS
OF
AMERICA
CHARTERED BY THE CONGRESS OF THE UNITED STATES

PREPARED STATEMENT OF JOSEPH M. ROMAGNANO, NATIONAL PRESIDENT
PARALYZED VETERANS OF AMERICA

Mr. Chairman and distinguished Members of the Committee, it is a privilege to appear before you today to present the legislative concerns of Paralyzed Veterans of America.

We would like to preface our testimony today by recognizing the continued service rendered by this Committee on behalf of America's veterans. The leadership shown by the Committee Chairman, the Honorable Alan Cranston, combined with the dedication and wisdom of the Members, are invaluable assets in meeting the needs of the men and women who have served this great nation.

4350 East-West Highway, Suite 900, Washington, D.C. 20014 (301) 652-2135

PVA is an organization of approximately 11,000 veterans who are members of 33 Chapters located throughout the nation. These veterans qualify for membership due to spinal cord injury or disease. Our membership is almost equally divided between service-connected disabled and non-service-connected disabled veterans.

In our testimony before this Committee during the First Session of the 96th Congress we enunciated many issues and concerns that adversely affected America's veterans. PVA would like to use this opportunity to thank the Members of the Committee and the entire Congress for the consideration given to and the actions taken on many of these problems. The legislation enacted during the past session of Congress does much to uphold and continue the commitment of the nation to the men and women who have served in the armed forces of the United States.

In order to rectify the many problems that continue to face severely disabled veterans, PVA is involved in various areas relevant to their concerns. We would like to begin by commenting on the budgetary reductions currently under consideration.

The need for fiscal austerity and a balanced federal budget are clearly important during this period of rapidly escalating inflation. It is also evident that all segments of America must act in a responsible and enlightened manner if these goals are to be met with the imposition of the least amount of hardship. However, it must be also stressed that blind, haphazard cuts of existing programs can frequently only create hardships for those individuals most in need of assistance.

For the budget of the Veterans Administration to be reduced from its already austere level without regard to the needs and sacrifices of veterans is a grave injustice to those who have served the nation. The cutting of programs predicated on mere expedience or because those affected appear to be politically impotent would be most injudicious and detrimental.

PVA firmly asserts that any additional cuts to an already inadequate budget would be an indication that the very existence of the Veterans Administration is in jeopardy. Attempts have already been made to eliminate or transfer to other federal agencies services provided to veterans by the VA.

The specter of reductions in the budget of the Department of Medicine and Surgery (DM&S) is especially troubling to us because adequate and timely health care is PVA's first priority. During the past several years there have been drastic reductions in personnel, beds, and funds available in the VA medical system. To further erode the needed financing for this health care system is to undermine the viability and substance of commitments made to the nation's veterans. The availability of medical services to veterans has already been diminished to an unprecedented low. Further diminution would be intolerable.

At a time when many veterans of World War II are beginning to place more demands on the VA hospital system the contemplation of anything other than strengthening the system is most alarming. The VA health care system must not be allowed to be reduced or even maintained at its present, inadequate level but must, instead, be upgraded and increased if the anticipated needs of veterans are to be served.

Indicative of the deteriorating conditions of the VA health care system are the concommitant problems of recruitment and retention of qualified health care professionals. This Committee will soon conduct hearings on the VA's retaining physicians and dentists, but we must note that the problem also extends to nurses, medical assistants, and nurses' aides. Not only is it becoming more difficult for the VA to recruit individuals for vacant positions but those health care professionals already in employ of the VA are being beset with ever greater problems of increased workloads and declining morale. Increased compensation alone will not rectify this disturbing situation. The need for adequate staff levels, programs of career advancement, a VA that is responsive and sensitive to the needs of its employees, and a return to a commitment to excellence in health care are required if these problems are to be overcome.

Another appalling example of the decline of the VA health care system is the increasing incidence of veterans in need of health services being forced to wait undue periods of time, receiving inadequate or untimely care, or being deprived of care altogether. With this occuring simultaneously with the number of beds being reduced, the construction of needed facilities being deferred, and programs being inadequately implemented, it appears that the VA is slowly and insidiously being dismantled. Despite these evident shortcomings the present Administration continues to insist that the quality of care has not suffered and that the DM&S budget can be further reduced.

In addressing the problems of the Department of Medicine and Surgery it becomes abundantly clear that the Office of Management and Budget (OMB), under the guise of fiscal responsibility, is perpetrating the demise of veterans' health care. All too frequently the intentions and mandates of Congress are being subverted by OMB. Several examples of this are evident when the implementation of recently enacted laws are scrutinized. First, in Public Law 96-22 the Administrator of the Veterans Administration was clearly provided the authority to establish parking regulations for VA employees but OMB imposed its own requirements for parking, much to the detriment of VA health care employees. It must be noted parenthetically that the Administrator acquiesced quite easily in this matter.

Second, Public Law 96-151 provides for an increase in per diem rates to state veterans' homes, a most beneficial and cost effective program. However, OMB disapproved funding for this during the remainder of FY 1980.

A final example of this disregard for Congressional intent is demonstrated in the fact that Public Law 96-151 gives the DM&S the authority to furnish nonprescription drugs, medicines, and supplies to eligible veterans when these services are determined to be "reasonable or necessary." OMB has applied an excessively restrictive interpretation to this provision, and, rather than viewing it as a means of providing eligible veterans with needed health care items, it proposed denying these benfits in order to save the government $10 million. PVA feels that such actions violate the intent of Congress and that these miniscule savings are at the expense of those veterans who are most in need.

Further erosion of health care for veterans can be envisioned when the Administration's FY 1981 budget is closely examined. The proposed increases in funding for FY 1981 in no way offset the detrimental effects of the present rate of inflation and can only result in a net reduction in services provided to veterans.

Additionally, the savings proposed by the VA which would accrue from third party reimbursement are highly suspect. The figure in no way agrees with other estimates for projected savings from such a measure. No such program presently exists and its legitimacy would be questionable. Finally, such an anticipated program appears to hide another attempt to exclude non-service-connected disabled veterans from needed health care services.

It becomes readily apparent that any program of third party reimbursement for health care services for non-service-connected veterans is another means of deleting existing medical benefits. It is foreseeable that if such a program were to be implemented those veterans without adequate health care coverage could be denied VA services due to their inability to pay or have paid on their behalf the cost of such services.

PVA must stress in addressing the needs of the VA health care system that our primary focus is on the continued maintenance and improvement of the Spinal Cord Injury service. While the SCI service has been suffering the same problems that beset all of DM&S such as low morale, increasing budgetary restrictions, and reductions in available services, it must also be pointed out that there are specific issues and problems unique to the SCI system.

One area of concern is the level of staff turnover that comes from low morale and associated problems inherent to the Spinal Cord Injury service. All levels of staff at SCI facilities must contend with the problems common to all of DM&S plus the physical demands associated with mobility-impaired patients and the psychological difficulty that comes from dealing, on a daily basis, with institutionalized patients. Long-term and sustaining care frequently provide little opportunity for professional interaction with colleagues and fewer opportunities to practice in fields of specialization.

In the Veterans Administration's recently published "Spinal Cord Injury Program FY 1980-1987" it was recommended that the three distinct categories of SCI care (intensive rehabilitation, sustaining care, and long-term) be separated and be carried out at separate facilities. PVA must assert that this proposal will lead to increased problems of recruitment and retention of qualified health care personnel and, will have a deliterious effect on the care for veterans who have experienced spinal cord injury or disease.

An alternative which PVA hopes this Committee will consider is the co-location of domiciliaries with specified, existing Spinal Cord Injury Centers. The advantage of this proposal, as opposed to that of the VA, are several. First, the patient mix afforded by such a system would help in alleviating the morale problems of SCI staffs that exist in the present system and that would be perpetuated and aggravated by the VA's proposal. Patients institutionalized at such domiciliaries would thereby be ensured of receiving adequate and immediate treatment from health care specialists who are familiar with the complications associated with spinal cord injury and disease. Finally, under the VA's proposal veterans would be required to seek care at centers which might be located at great distances from their homes and families. Such geographic separation would only serve to increase the hardships imposed upon such significant family members who are so vital to the veteran's ultimate return to a full and productive life.

Great distances already are a burden to those veterans living west of the Mississippi River because there are only three Spinal Cord Injury Centers located in this section of the United States. Veterans in the Upper Midwest and the Mountain States must travel to the West Coast, Milwaukee, Chicago, or St. Louis if they are to receive treatment at an SCI center. PVA strongly requests that this Committee consider the locating of a Spinal Cord Injury Center in this area of the nation. Another Spinal Cord Injury Center is needed to serve the Greater Detroit Metropolitan area. One of America's largest cities with an extensive veterans population, Detroit would be well served with the addition of such a vital facility. The VA proposes the refurbishing of the Allen Park, Michigan, VA Hospital, but PVA recommends that this antiquated facility be replaced with a new facility which would include a Spinal Cord Injury Center.

PVA would like to address vocational rehabilitation, another important issue directly related to a disabled veteran's return to a productive and satisfying life. We would first like to express our gratitude to this Committee for its recent considerations for improving the invaluable programs in Chapter 31, Title 38, United States Code, and we hope that a restructured, comprehensive program of rehabilitation will soon come to fruition.

We must stress that regardless of which of the legislative proposals is passed by the Congress, certain fundamental provisions and programs must be included if the rehabilitation program of the Veterans Administration is to achieve its goal. Foremost is the concept of comprehensive rehabilitation that involves the active involvement of both the Department of Medicine and Surgery and the Department of Veterans' Benefits. Rehabilitation, in order to be effective, must be a comprehensive, integrated process which gives continuing attention to physical, psychological, social, family and economic pressures that increase as a result of a person's disability.

A second critical concept inherent to a modern, successful vocational rehabilitation program is that of employment rather than employability. Rehabilitation must prepare and train the individual for employment, but, equally as important, it should define rehabilitation as completed only when the individual has successfully, and for a specified period of time, maintained suitable employment or attained maximum independence.

Finally, it is widely accepted that the primary objective of comprehensive rehabilitation is to facilitate the optimal vocational development and adjustment of disabled persons. Implicit within this statement is the concept that satisfactory vocational adjustment encourages adjustment in other daily living activities. The inclusion of a program of independent living centers must be included in any system of comprehensive rehabilitation if the needs of severely disabled veterans are to be met. For those veterans whose severe disabilities preclude employment goals, the concept of making independent living services available is fundamental to their achieving maximum independence and meaningful lives.

Another of the most beneficial programs administered by the VA is compensation for veterans who have experienced service-connected disabilities. Compensation is for many of PVA's members the next most important of their entitlements because, for catastrophically disabled veterans, it remains basically their primary source of income maintenance.

Congress created the compensation program in an effort to offset the loss of earning capability sustained by the veteran in service to his nation. PVA would like to express its appreciation to the Members of this Committee for frequently examining the various aspects of this program and for taking appropriate action on areas that need improvement. Also, we would like to acknowledge our gratitude for examining the rates of compensation in order to ensure that these veterans receive adequate care.

During the First Session of the 96th Congress this Committee did not hesitate to reconsider the rate of increase for compensation when it became evident that the rate of inflation was, based on the Consumer Price Index, exceeding what was originally anticipated. PVA gratefully acknowledges this concern for veterans' needs.

It has become obvious that an improved method of computing compensation benefits must be employed if the standard of living for the most severely disabled veterans is not to decline. During the past three years the rates of increase in compensation have increasingly fallen below the rates of inflation as based on changes in the December to December Consumer Price Index (CPI). This means that, even with these increases in the compensation rates, these veterans have suffered a real decline in their financial well-being.

PVA fully understands that the sole purpose of Chapter 11 of Title 38 is to offset the diminished earning capacity of service-connected disabled veterans. Furthermore, we recognize that in this time of rampant inflation it is becoming more difficult for Congress to ensure that such veterans do not suffer a decline in their economic status.

In order to meet this dual problem of escalating inflation and declining relative compensation rates, PVA suggests that for those veterans who are rated 70 percent or more disabled because of service-connected disabilities the annual increase in compensation payments should be indexed to the CPI.

PVA does not desire to see veterans with lower levels of disability harmed by the effects of inflation. But, we strongly feel that for those veterans who are seriously disabled and cannot, generally, supplement their incomes through gainful employment, the situation becomes especially crucial as inflation continues to erode their financial security.

According to the VA's statistics of June 1979, fewer than 12 percent of all veterans in receipt of compensation were rated at 70 percent or greater disability. Therefore, this relatively small number of service-connected severely disabled veterans could be compensated in this manner for their drastically reduced earning capability without excessive cost to the government.

Congress has already recognized the differing needs of certain categories of disabled veterans when it authorized, under Section 314(r) of Title 38, United States Code, that the most seriously disabled veterans would be entitled to a special aid and attendance (A&A) allowance. The "Veterans' Disability Compensation and Survivors' Benefits Act of 1978" (P.L. 95-479) provides that veterans who are service-connected disabled and eligible for A&A may receive up to $900 per month for special aid and attendance, without which they would require hospital or nursing home care.

This provision of Title 38 is an effort to de-institutionalize catastrophically disabled veterans, when at all possible. However, this provision is not being implemented according to Congressional intent because the VA arbitrarily considers veterans' spouses to be "unauthorized" attendant personnel.

PVA understands the provisions of Section 314 to mean that spouses or other individuals can serve in the capacity of attendants, because the Department of Veterans' Benefits' Circular 21-78-10 (Change 1, page 19) states: "To become entitled to this benefit, a veteran must submit evidence that he/she is receiving on a daily basis at home the services of a licensed health care professional or a person acting under the regular supervision of a professional." Several additional implications in the Circular support this direct statement that non-professional attendance, so long as it is professionally supervised, qualifies a catastrophically disabled veteran for the increased A&A allowance.

Even though the DVB published this Circular on November 14, 1978, the spouses of a number of PVA's service-connected disabled members are not being considered as qualified attendant personnel, even though they work under physicians' supervision and have cared for these veterans for years. It is important to note that the spouses of our most catastrophically disabled members have received formal training at the various VA Spinal Cord Injury Centers. They have usually been trained, both formally and practically, to care for the veteran in his daily needs.

We noted earlier that this is due in large part because of the VA's arbitrary interpretation of Section 314(r)(2). PVA has requested for over a year that various Regional Offices adhere to the intent of Public Law 95-479 whereby spouses who function as attendants under professional guidance do, in fact, qualify as attendant personnel and that such veterans thereby qualify for the increased A&A allowance.

Members of this Committee worked long and hard for passage of this vital legislation and we remain forever grateful. However, as is too often the case, the regulations which control implementation of legislation do not reflect Congressional intent. Therefore, PVA requests that the Veterans Administration be directed to implement this and other laws as intended by Congress.

PVA remains grateful to the Members of this Committee for their diligence in caring for the needs of service-connected disabled veterans who have made great personal sacrifices in service to the nation. We fell confident that Congress will take whatever steps are necessary to secure for these individuals and their families meaningful lives of dignity, thereby honoring the nation itself in keeping its promises to those who have served it in its times of need.

Furthermore, Congress has recognized the nation's debt to non-service-connected disabled veterans who, likewise, gave of themselves during times of war. We request that this Committee consider a legislative proposal recently introduced in the House of Representatives at PVA's request, H.R. 5951, which would amend Title 38 to provide an incentive for severely disabled veterans who are in receipt of pension to live outside an institutional setting. This bill would increase the aid and attendance (A&A) allowance to a level that would enable the individual to live independently.

PVA must emphasize the need for a significant increase in the aid and attendance allowance for non-service-connected veterans. Such an increase is of great importance if the recently established pension program is to fully meet the needs of those it was designed to assist. It should be noted that it costs approximately twice as much to maintain an individual in a hospital as it does in an institution such as a nursing home, but it would cost less than half this latter amount per individual per month if the provisions of H.R. 5951 become law and the veteran lives independent of the institutional setting. At this time of increasing fiscal restraint this factor should certainly be considered. Additionally, we trust that the Members of this Committee will recoginze that the quality of life is more fulfilling for most individuals, whenever possible, if they live independently.

Independence offers dignity for these veterans and, for many, family life provides fulfillment. However, because of the increasing expenses of providing adequately for a family, many seriously disabled veterans and their spouses have determined recently that the most appropriate way of meeting these costs in their particular cases is for the spouses to seek employment. Such a measure has placed some of these veterans in a financial predicament since passage of Public Law 95-588, the "Veterans' and Survivors' Pension Improvement Act of 1978."

Public Law 95-588 was passed by Congress with the intent of allowing non-service-connected disabled veterans in receipt of pension to elect between the older, lower pension rates or the more recent, higher ones. The latter group was subject to one particular stipulation, that spouses' income was to be counted in computing veterans' eligibility for pension.

Considering spouses' income for computation of pension benefits proved at first to be no obstacle for many of these veterans because their spouses were not gainfully employed. However, because of the increasing necessity for additional income many spouses have subsequently become employed. The result is that in an effort to help themselves, these families are not benefitting from their efforts because the individual veteran's pension is reduced due to the spouse's earnings.

Another aspect of this problem is that many veterans who elected the newer pension program but have subsequently married are finding their benefits greatly reduced if their spouses are gainfully employed, even at marginally paying jobs.

PVA requests that Congress amend Title 38 to provide for at least a partial income exclusion in cases where non-service-connected disabled veterans' spouses are gainfully employed.

Another issue that affects married disabled veterans is Disability and Indemnity Compensation (DIC). Congress passed the "Veterans' Disability Compensation and Survivors' Benefits Act of 1978," a very beneficial law that extends DIC benefits to surviving spouses and children of certain veterans who were rated 100-percent service-connected disabled at the time of death, but whose deaths have not been determined by the VA to be service-connected.

PVA commends this Committee for proposing this legislation to provide for the survivors of those veterans who have a shorter life expectancy and, quite importantly, may not be able to accumulate an estate sufficient to provide for their survivors. While the Benefits Act of 1978 has generously extended DIC benefits to certain survivors, there remains the greatest inequity of all, that the survivor receives DIC benefits based on the veteran's military pay grade. We understand the rationale for awarding DIC based on pay grade when a serviceman dies while in active military service. We also understand that DIC is intended to provide only partial compensation to the designated survivors for the loss in financial support sustained as the result of service-connected death. However, surviving spouses of these veterans who were severely disabled for many years deserve, in our opinion, a greater benefit.

A surviving spouse who receives DIC may be willing to seek employment to supplement her income, but she would, in most cases, not have marketable job skills due to the constant care needed by the veteran until his death. In addition, the spouse must seek employment at a time in life when most full-time employees would be considering retirement. We believe the nation has a greater moral obligation than that currently assumed and should provide more adequately for these survivors.

We urge the Committee to propose legislation to restructure the DIC program to award payment on the basis of disability of the person when death does not occur during military service and to increase the DIC rate to at least 75 percent of the disabled veteran's monthly compensation rate at the time of death.

The National Service Life Insurance (NSLI) program also needs to be amended if the security of disabled veterans and their families is to be maintained. Frequently the disabled veteran, due to his reduced earning capacity and his inability to secure private life insurance, is unable to accumulate an estate adequate for the needs of his surviving spouse and dependents. PVA recommends that the maximum allowable limit for NSLI be increased from $10,000 to $50,000. This increased amount, more realistic in terms of today's rapidly escalating living costs, would provide the veteran with the knowledge that his survivors would be cared for after his death. It should be noted that the maximum allowable limit for NSLI has not been increased since the 92nd Congress.

As millions of World War II veterans are approaching sixty years of age it is vitally important that Congress promptly pass legislation that would help care for the surviving spouses of those who suffered severe disabilities in service to the nation.

In addition to the need for increased DIC and NSLI benefits the educational needs of many deserving spouses is not being met. There continues to be a requirement for alteration of the educational benefits offered under Chapter 35 of Title 38. PVA strongly recommends the elimination of the ten year delimiting period for the spouse of a severely disabled veteran in order that she can receive the educational benefits available under Chapter 35. Such a spouse is freqently confronted with additional homemaking cares, child rearing responsibilities, and financial obligations, in addition to attending to the specific requirements of the disabled veteran. All of these pressures preclude the utilization of education benefits provided for by Chapter 35, because in such cases the spouse often must wait several years before beginning her educational program.

When the veteran dies, the spouse is frequently faced with seeking employment. It is at this time that these educational benefits could be of their greatest value and would accomplish the most in meeting the needs of the surviving spouse.

Mr. Chairman and Members of the Committee, as National President, and on behalf of the members of Paralyzed Veterans of America, I thank you and your extremely capable staff for the cooperation and consideration which you have shown our organization. We look forward to working with you in the future and to presenting in detail these and other issues which are of concern to America's veterans. PVA sincerely appreciates your allowing us to express here today our needs, views, and concerns.

APPENDIX

Veterans Administration

1979 Annual Report

Administrator of Veterans Affairs

64-263 O—80——13

Letter of Transmittal

To the President of the Senate and the Speaker of the House of Representatives of the 97th Congress:

In accordance with provisions of 38, U.S.C., 214, I have the honor of submitting a report on the activities of the Veterans Administration for the fiscal year ending September 30, 1979.

During the course of the year this agency operated a broad range of programs with a budget of $19.9 billion to benefit the nation's veterans, their dependents, and their survivors. These benefits were administered within a framework of goals and priorities derived from the VA mission—to provide compassionate assistance and service to veterans of the armed forces and to eligible dependents and survivors. Agency goals and priorities are spelled out in the following statements.

For veterans whose disabilities resulted from military service, we shall provide:

- Comprehensive, high quality medical care, rehabilitative therapy, and prosthetic devices;
- Monthly compensation payments for the effects of disability;
- Vocational rehabilitation to restore the veteran to employability;
- In specific instances, grants for specially equipped homes and automobiles;
- Insurance at preferential rates.

For veterans who need assistance in the transition to civilian life, we shall help them make up for lost opportunities by providing:

- Financial support and other services for education and training;
- Assistance in obtaining home loans.

For the aged or needy veteran with non-service connected disabilities, we shall provide:

- Income-tested pensions for wartime veterans;
- Medical care in the VA medical system if space is available.

For deceased veterans we shall give special recognition by providing:

- A burial site;
- Financial assistance for burial expenses;
- An appropriate memorial.

For eligible survivors and dependents of veterans, we shall help them overcome the effects of the veteran's disability or death by providing:

- Monthly compensation payments to survivors of veterans whose death was related to military service;
- Education and training for dependents of totally disabled veterans and survivors of veterans whose death was related to military service;
- Income-tested pensions for needy, eligible survivors of disabled wartime veterans;
- Interment in a national cemetery.

For the nation, we shall support the quality of the VA health care system and use it as a national health resource by:

- Conducting medical and rehabilitative research;
- Training physicians, dentists, nurses, and other health professionals.

Effective accomplishment of these wide-ranging goals requires that priorities be established to guide the agency's policy makers and decision makers at all levels. The Veterans Administration gives the following matters priority in its operations:

- To provide compassionate competent assistance to veterans and their dependents in every phase of operations.
- To provide priority attention to the service connected disabled veteran in the VA health care system.
- To enhance the quality of life for disabled veterans through an improved, comprehensive, and integrated program of rehabilitation services and research.
- To ensure that we are effectively reaching out to veterans to inform them of their benefits and to encourage them to use them.
- To develop effective programs to serve incarcerated veterans.
- To ensure that we plan effectively for the particular needs of the aging veteran.
- To develop and maintain equal employment opportunity, affirmative action and other Human Goals programs that will serve as models in the achievement and protection of equality and human rights.
- To accomplish aggressively the actions for Vietnam veterans as identified in the Presidential Policy Review Memorandum.
- To provide for adequate gravesite availability for future needs and for appropriate memorialization for our nation's veterans.
- To provide drug and alcohol treatment facilities and broaden the care available for these problems.
- To upgrade the quality of all VA facilities.

These were the VA's mission, goals, and priorities during FY 1979. They will be refined as needs dictate, and will constitute the blueprint for future years during which we shall strive to continue to improve service to those who deserve our thanks as a nation.

Sincerely,

Max Cleland

MAX CLELAND
Administrator

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The Veteran

Comparative Highlights

Period of Service	Veteran Population ¹ Sept. 30, 1978	Net Separations from Armed Forces	Deaths in Civil Life	[redacted]	Percent Change
Total veterans²	29,999,000	440,000	367,000	[redacted]	0.2
War veterans²	26,472,000	196,000	358,000	[redacted]	0.6
Vietnam Era Total	8,734,000	196,000	20,000	[redacted]	2.0
With no Korean conflict service	8,194,000	184,000	15,000	[redacted]	+2.1
With Korean conflict service	540,000	12,000	5,000	[redacted]	+1.3
Korean conflict Total	5,899,000	12,000	45,000	[redacted]	0.6
With no World War II service	4,605,000	11,000	27,000	[redacted]	−0.3
With World War II service	1,294,000	1,000	18,000	[redacted]	1.4
World War II Total	12,911,000	1,000	238,000	[redacted]	1.8
With no Korean conflict service	11,707,000		220,000	[redacted]	1.9
With Korean conflict service	1,204,000	1,000	18,000	[redacted]	−1.4
World War I	672,000		78,000	[redacted]	11.6
Service between Korean conflict and Vietnam era only	3,068,000	–	9,000	[redacted]	0.3
Post-Vietnam era	459,000	244,000	–	[redacted]	+53.2

¹ Revised

² Not included are Spanish-American War veterans who numbered [illegible] on September 30, 1978 and [illegible] on September 30, 1979; [illegible] died during FY 1979

Summary

The history of the United States has been marked by periods of armed conflict in which nearly 39 million of the country's men and women have served in the armed forces. Nearly 1.1 million of these servicepersons sacrificed their lives in the defense of our country during these periods of war. Today there are approximately 26.3 million living war veterans, all of whom saw service in wars fought in the 20th century (i.e., Spanish-American War, World War I, World War II, Korean conflict and Vietnam era). Six hundred thirty-five thousand died in service during those five wars in which a total of 36 million served. In addition to the 26.3 million living war veterans, there are over three million veterans who served only during the peacetime period between the Korean conflict and the Vietnam era as well as 703,000 peacetime veterans who entered military service after May 7, 1975, and have since returned to civilian life.

Number of Veterans and Period of Service

The number of living veterans increased during FY 1979 to 30,072,000, a growth of 73,000 or 0.2 percent more than at the end of FY 1978. This growth in the veteran population results from the addition of 456,000 service personnel discharged from active duty military service, which was partially offset by the reentry into active duty service of 16,000 who had previously returned to civilian life and the loss of 367,000 veterans who died during FY 1979.

Living veterans with service only in the Vietnam or post-Vietnam era periods increased in number. A net growth of 2 percent in the number of living Vietnam era veterans occurred as 196,000 were discharged from the armed forces and 20,000 died during the fiscal year. The post-Vietnam era veteran population expanded by 53.2 percent as 244,000 who served in the armed forces only after May 7, 1975 were discharged to civilian life. Fewer than 500 deaths occurred among these peacetime veterans during FY 1979. The addition of 12,000 men and women separated from the armed forces during FY 1979 who had served during the Korean conflict was insufficient to offset the 45,000 who died during the same period. The number of living Korean conflict veterans decreased during the year by 0.6 percent to 5,866,000. Five hundred forty-seven thousand of the end-of-the-year Korean conflict veteran population had also served during the Vietnam era. Thirty-two years have passed since the entitlement period for World War II benefits came to an end; approximately 1,000 persons with World War II service were separated from the armed forces during FY 1979, but 238,000 veteran deaths during the year decreased the World War II population by 1.8 percent to 12,674,000. The number of living World War I veterans was decreased by 78,000 deaths (11.6 percent) during FY 1979. The number of peacetime veterans who served only between the Korean conflict and the Vietnam era declined to 3,059,000 as 9,000 died during the fiscal year.

Age of Veterans

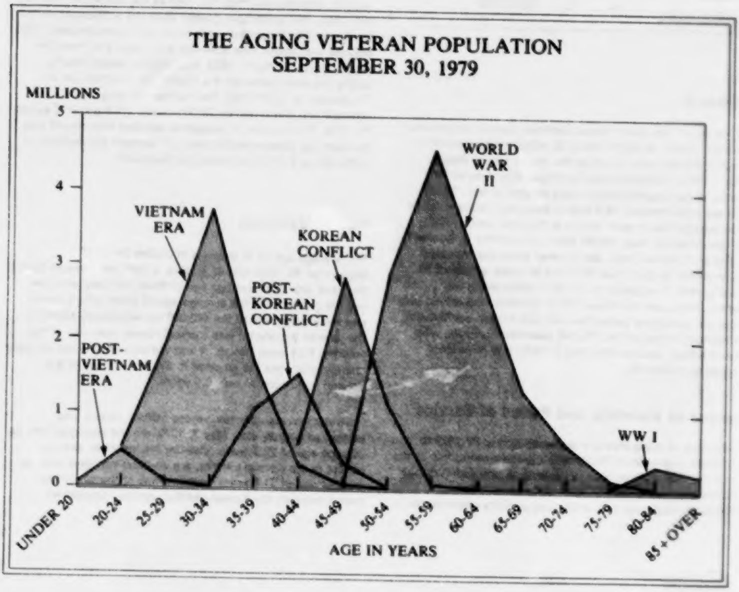
The average age of all veterans in civilian life as of September 30, 1979 was 47.5 years, a half-year increase during the fiscal year. The average age of those veterans who died was far greater than the average age of those who survived and the average age of the 440,000 net separatees added to the veteran population was markedly lower than that of the veterans they were joining. It was the combined effect of these changes that held the advance in the average age of the veteran population to only 0.5 years.

Post-Vietnam era veterans, whose military service was performed entirely after May 7, 1975, are the youngest with an average age of 22.3 years. Vietnam era veterans, with no service in the Korean conflict, are the next youngest with an average age of 31.6 years, and veterans of the peacetime period between the Korean conflict and the Vietnam era average 40.7 years. Korean conflict veterans, with no service in World War II, average 47.9 years which is 0.4 years above the average age of the entire veteran population. World War II veterans, who comprise 42.1 percent of the total veteran population, have an average age of 59.1 years. World War I veterans, all of whom are now more than 75 years old, have an average age of 84.0 years. As of the end of the fiscal year, there were 209 veteran survivors of the Spanish-American War with an average age of 101.1 years.

Veterans 65 years of age or older now total more than 2.75 million (nearly one of every 11 living veterans), an increase of 217,000 during the past year. Greater future increases in this older population can be foreseen in the accompanying chart. The present population of 60-64 year old veterans (2,986,000) will enter the older population group within the next five years. Similarly, the surviving veterans among those presently in the 55-59 year age group (4,633,000) will enter the "65 years and older" veteran population during fiscal years 1985 through 1990. By 1990 approximately one of every four veterans will be 65 years old or older. At the other end of the age spectrum, the number of veterans under 30 years of age decreased by 314,000 to 3,216,000 at the end of FY 1979. This occurred as the number of 29-year-old Vietnam era veterans who became 30 exceeded the number of Vietnam era and post-Vietnam era veterans under 30 years of age released from the armed forces.

Female Veterans

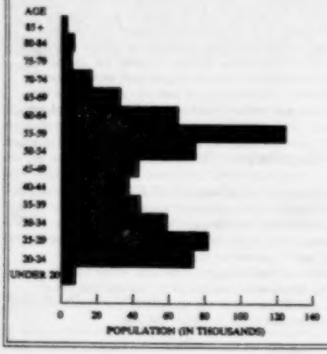
The female veteran population at the end of FY 1979 is estimated to be 679,000, nearly 2.3 percent of the total veteran population. Beginning with World War I, women have served in the armed forces in every period of conflict. The largest group of female veterans living today are those who served during World War II (289,000); the smallest group (9,000) is from World War I. An estimated 74,000 are Korean conflict veterans (with no service in World War II) and 188,000 are Vietnam era veterans (with no service in the Korean conflict).


THE AGING VETERAN POPULATION
SEPTEMBER 30, 1979

There are 98,000 female peacetime veterans who served only between the Korean conflict and the Vietnam era. The most rapid growth in numbers of female veterans is among the post-Vietnam era group. Increasing dependence of the armed forces on women since the inception of the all-volunteer force is apparent from the FY 1979 increase of 25,000 female post-Vietnam era veterans. At the end of FY 1979 the post-Vietnam era female veteran population was 63,000.

The reliance of the military services on women to fulfill their recruiting requirements is also apparent from their age distribution. The number of female veterans under 30 years of age increased 24 percent during FY 1979 from 144,000 to 164,000. The average age of all female veterans is 45.5 years, somewhat lower than that of the entire veteran population.

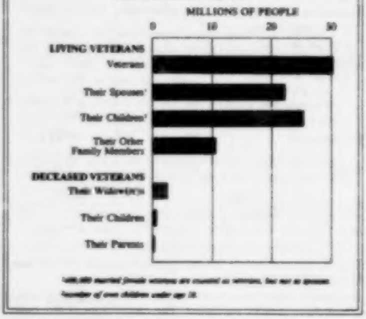
TOTAL FEMALE VETERAN POPULATION BY AGE: SEPTEMBER 30, 1979



Veterans and Their Families

Veterans in civilian life account for only about one-third of all people potentially eligible for VA benefits and services. It is estimated that three-quarters of veterans are married. Their 23.8 million spouses, 24.4 million dependent children (under 18 years of age), and 11.1 million other family members (including children 18 years of age or older) combined with the 30.1 million veterans themselves total up to more than 90 million. Although only a small proportion of these dependents are likely to receive benefits directly from the VA at any time in the future, benefits paid to veterans indirectly affect the socioeconomic well-being of a great number of them. In addition to the dependents of living veterans, there were 3.6 million survivors of deceased veterans at the end of FY 1979. This number is comprised of 2.9 million widows and widowers, 0.6 million surviving children and between 0.1 and 0.2 million dependent parents. The total of all these potential beneficiaries is over 90 million or approximately 41 percent of the entire U.S. population.

VETERANS AND THEIR FAMILIES
SEPTEMBER 30, 1979



Characteristics of Veterans

The VA obtains data on various socioeconomic characteristics of male veterans [1] and nonveterans from the Current Population Survey (CPS) through a contract agreement with the Bureau of the Census. Data from the Current Population Survey includes educational attainment, income, work experience, school enrollment, and employment status.

It should be noted that although differences in median income and work experience of veterans and nonveterans are shown, these differences may be largely explained by variances in their age distributions. If the nonveterans' age distribution is made to conform with that of veterans, differences in these areas are reduced considerably.

Educational Attainment and Income

All Veterans. In March 1979 there were 67.9 million male veterans and nonveterans, aged 20 years and over, in the civilian noninstitutional population of the United States. Veterans, who represent 28.7 million of this number, had a median education level of 12.7 years compared with a median of 12.6 years attained by their 39.2 million nonveteran male counterparts.

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[1] *The Current Population Survey asks only males if they have ever served in the armed forces. If data on female veterans were collected in that survey, the sample would be so small that any data on characteristics of female veterans would be considered unreliable or unrepresentative of the population. Data on female veterans will be collected on the long form of the 1980 Census which will be mailed to about 15 to 20 percent of American households.*

Population Group	Noninstitutional Population (In Thousands)	Percent of Total
War veterans	25,355	37.3
Peacetime veterans (Post-Vietnam era and service between Korean conflict and Vietnam era only)	3,376	5.0
Nonveterans	39,181	57.7
Total	67,912	100.0

Seventy-four percent of the war veterans over 20 years of age, 85 percent of peacetime veterans, and 67 percent of nonveteran males had completed the requirements for a high school diploma or its equivalent. The percentages of the three groups who had college degrees were: war veterans, 19 percent; peacetime veterans, 20 percent; and nonveterans, 18 percent.

Greater educational attainment almost invariably leads to increased earning capability, and this held true during calendar year 1978. The differences were dramatic; individuals with four or more years of college had a median income more than two-and-a-half times as large as those with eight years of education or less. The median income for veterans ranged from a low of $8,030 for veterans who had less than a high school education to a high of $23,150 for those veterans who had received college degrees. Nonveteran males with less than a high school education had a median income of $5,670, but those who were college graduates had a median income of $16,570. The increment in income which accrues to those who complete college, whether they are veterans or nonveterans, is considerable.

An exception to the rule that more education results in more income occurs among nonveterans with one to three years of college. Their median income was more than $1,200 less than that of nonveteran high school graduates who had *not* gone to college. This drop in income may be traced to the fact that the average age of nonveterans with some college is much lower than the average age of nonveteran high school graduates; these younger nonveterans have less work experience and less job seniority. In addition, there is a much greater chance that they have been in school during most of the year. The median income of veterans was higher than that of nonveterans at every level of educational attainment, as the accompanying table shows.

Attained Level of Education	Median Income in 1978	
	Veterans	Nonveterans
Less than high school	$ 8,030	$ 5,670
Some high school	11,500	8,310
High school graduates	15,070	11,390
Some college	16,250	10,180
College graduate	23,150	16,570

Vietnam Era Veterans. Vietnam era veterans under 40 years of age had a median educational level of 12.9 years and a median income of $14,690 in 1978. Similar-aged nonveterans had the same median educational level but a personal income of $10,820. However, 9 of 10 Vietnam era veterans compared with 8 of 10 nonveterans aged 20-39 years were high school graduates. Despite the greater proportion of high school graduates among veterans, the percentage who had completed a college degree was smaller than for nonveterans - 20.6 percent of Vietnam era veterans and 22.8 percent of nonveteran males under 40 years of age.

Work Experience

All Veterans. About 94.5 percent of all male veterans in the civilian noninstitutional population worked at some time during calendar year 1978; this contrasts with 80.6 percent for nonveteran males. Eighty percent of the 21.4 million working veterans and 71 percent of the 31.6 million working nonveterans worked throughout the year, either full-time or part-time. Ninety-seven percent of the veteran year-round workers and 94 percent of the nonveteran year-round workeres held full-time jobs for all or part of the year.

Vietnam Era Veterans. Ninety-seven percent of all noninstitutional male Vietnam era veterans under 40 years old worked during calendar year 1978. Seventy-six percent of the 7.5 million Vietnam era veterans who worked had year-round employment. Ninety-five percent of the nonveteran males under 40 years old worked during the year and about 69 percent of these nonveterans worked year-round.

Employment Status

War Veterans. The unemployment rate for all male war veterans in FY 1979 dropped 0.4 percentage points from FY 1978 to 3.2 percent. The unemployment rate for male nonveterans also fell 0.4 percentage points to 6.2 percent.

Vietnam Era Veterans. There were 8.1 million Vietnam era veterans in the civilian labor force on the average during FY 1979. Of this number, 357,000 were unemployed, which produced an annual unemployment rate of 4.4 percent. The unemployment rate for the youngest Vietnam era veterans (those under 25 years old) was 11.6 percent.

Family Income

War Veterans. The median income of the 20.7 million families headed by male war veterans was $21,780 in calendar year 1978, compared with $17,350 for families headed by nonveterans. Wives worked in 54 of 100 families headed by war veterans and 53 of 100 families headed by nonveterans. Among families headed by veterans, the wife's earnings increased the median family income to $23,980 compared with $18,910 when the wife did not work. Median family income ranged from a high of $26,430 for families headed by veterans 45-49 years old, to a low of $10,710 for families whose veteran head was 70 or more years old. Total income declines rapidly for families whose veteran head reaches the age of retirement, from a median of $23,280 when the veteran family head is 55-59 years old to $20,240 when the family head is 60-64 years old, to $13,980 when he is 65-69 years old and $10,710 at age 70 and over. Taking all 20.7 million veteran families into consideration, one of 20 had a family income below $6,500 in 1978.

Vietnam Era Veterans. There were 5.7 million families headed by 20-39 year old male Vietnam era veterans in the United States in March 1979. Four percent had incomes below $6,500, but the median family income in 1978 was $19,900 compared with $18,880 for families headed by similar-aged male nonveterans. In 66 of 100 families headed by Vietnam era veterans the wife worked, increasing the median income to $20,880 compared with $18,350 for those young veterans' families in which the wife did not work.

Survey of Veterans

A nationwide survey of veterans was conducted during FY 1978 under a contract with the Bureau of the Census. A sample was drawn from households which had previously been included in its Current Population Survey (CPS) but had now been retired from the survey. Survey of Veterans (SOV) questionnaires were mailed to a sample of about 14,750 male members of CPS households who indicated they had served in the armed forces of the United States; of these about six percent were classified by the beginning of calendar year 1978 as final non-interview cases - that is, the individuals had died, were institutionalized, or were not veterans of *active duty* military service despite having been in the military service for training only. Of the 13,848 veteran cases left that might be expected to be available, 76.1 percent responded to the questionnaire prior to the personal follow-up phase, a figure that rose to 83.5 percent (or 11,558 cases) after follow-up. Some of the preliminary findings from the survey are:

- 19 million (of the 29 million) living veterans have been recipients of at least one veterans' benefit at some time since leaving the armed forces.
- 7 million veterans received at least one veterans' benefit during the 12 months preceding the survey.
- About 85 percent of all veterans have health insurance and about 80 percent of Vietnam era veterans have such coverage.
- More than half (53.4 percent) of all veterans hospitalized in VA facilities during the 12 months preceding the survey indicated they had health insurance.
- The distribution by percent of service-connected disability is virtually identical for white and black veterans in receipt of VA compensation payments.
- By period of service, Korean conflict veterans had the greatest proportion of GI life insurance in effect at the time of the survey; Vietnam era veterans with active policies held policies with a larger face value.
- Almost 3 of every 4 Vietnam era veterans said they were aware of VA educational benefits prior to their separation from military service.
- Only 28 percent of all veterans who had used a VA home loan indicated they would have been able to purchase their first home without it.
- Over 3.9 million living veterans may choose to be buried in a National Cemetery; more than 19 million want their graves to be marked with a VA-provided headstone or marker.

New Legislation

The following laws enacted during FY 1979 are of particular interest to the VA, veterans, and their families and survivors.

Public Law 95-452 - Inspector General Act of 1978

Offices of Inspector General were established in 12 departments and agencies, including the VA, to promote economy and efficiency and prevent fraud and abuse in agency programs. The Inspectors General are required to conduct audits and investigations; review legislation and regulations of their agencies; make recommendations; and submit to the Congress, through the head of the agency, semiannual reports of their activities and findings and immediate reports of any particularly serious problem or abuse.

Public Law 95-476 - Veterans' Housing Benefits Act of 1978

The VA home loan program was amended to (1) increase from $25,000 to $30,000 the maximum grants for specially adapted housing for disabled veterans; (2) increase from $17,500 to $25,000 the maximum guaranty on VA home loans; (3) expand VA services in purchase of converted condominiums and mobile homes, and in home improvement and energy conservation loans; and (4) extend eligibility to Vietnam era veterans with 90 or more days of service (previously 180 days).

The VA education loan program was amended to provide for new eligibility and repayment requirements and an annual report on loan defaults.

This law also authorized financial aid for establishing and improving state veterans' cemeteries and for burial of veterans in veterans' cemeteries maintained by states or their subdivisions. The headstone and memorial marker program was improved to allow a wider variety of materials and reimbursement for nongovernment headstones and markers.

Public Law 95-479 - Veterans' Disability Compensation and Survivors' Benefits Act of 1978

Compensation and allowances based on service connected disability or death were increased. Threshold of disability at which additional compensation for dependents becomes payable was lowered from 50 percent to 30 percent. New rates of compensation were established for the loss or loss of use of three extremities or service connected loss followed by non-service connected loss of paired extremities. Dependency and indemnity compensation eligibility was extended to non-service connected deaths of totally disabled service connected veterans. Medal of Honor pension rates were increased. Burial allowances were increased for both service and non-service connected deaths.

In addition, this law clarified the tax exemption of service retirement pay equal to retroactive compensation or pension, provided memorial markers for veterans whose remains are not recovered, required a study of the adequacy of the compensation and health care available to former prisoners of war, required that cemetery superintendents and assistant superintendents employed by the American Battle Monuments Commission be U.S. citizens, and provided for a commemorative plaque at the Arlington National Cemetery for the members of the Armed Forces who lost their lives in the war in Southeast Asia.

Public Law 95-513 - Vietnam Veterans Week

This law provides for "Vietnam Veterans Week" and appropriate public ceremonies during the week of May 28, 1979.

Public Law 95-520 - The VA Programs Extension Act

This law extends VA authority to enter into special pay agreements with doctors and dentists; to provide private fee-basis hospital and medical care in Alaska, Hawaii, Puerto Rico, and the Virgin Islands; and to maintain a regional office and contract for medical services in the Philippines. It also requires a report on medical services in Puerto Rico and the Virgin Islands, and extends and improves excepted Federal Civil Service appointments for Vietnam era veterans.

Public Law 95-524 - Comprehensive Employment and Training Act (CETA)

This law extended the CETA programs and directed more extensive use of VA on-the-job training and apprentice programs and increased participation of veterans in planning councils and in training and employment programs.

Public Law 95-588 - Veterans' and Survivors' Pension Improvement Act of 1978

A new pension program was established to correct the deficiencies and inequities of the previous program and to assure veteran pensioners of an income exceeding the minimal standard of need, with automatic annual cost of living adjustments. Parents' dependency and indemnity compensation rates were increased 7.1 percent and provided with similar automatic annual cost of living adjustments. Veterans of the Mexican border period and World War I were granted an additional pension increase of $960 per year. Persons already receiving VA pension could elect the new pension or remain under the previous program.

The Administrator of Veterans Affairs was directed to conduct a comprehensive study of the income and other characteristics of veterans and their survivors residing outside of the fifty states and the District of Columbia, to estimate the present and future costs of their pension benefits, and to submit a report and recommendations to the Congress and to the President by February 1, 1980.

Public Law 95-600 - The Tax Revenue Act of 1978

Among other provisions of this act, employers received tax credit for hiring young disadvantaged Vietnam era veterans and veterans referred to the employer after completion of vocational rehabilitation under Title 38 U.S.C.

Public Law 96-22 - Veterans' Health Care Amendments of 1979

This law provided a new program of readjustment counseling and related mental health services and authorized five-year pilot programs of preventive health care services and drug and alcohol treatments in community-based facilities. It extended outpatient dental treatments to former prisoners of war and veterans with service connected total disability, restored limited authority for fee-basis medical services for veterans eligible for regular aid and attendance or housebound benefits, and authorized reimbursable emergency VA medical services at national conventions of veterans' organizations. Appropriations were authorized for garage and parking construction at VA medical facilities. Stricter requirements were imposed on recognition of adoption of children in foreign countries. Medical, hospital, and nursing home care within the U.S. was authorized for service connected disabilities of Philippine Commonwealth Army veterans and new Philippine Scouts. Nationally recognized medical researchers were authorized to accept travel and subsistence expenses from non-Federal organizations for attendance at meetings, acceptance of significant awards, or performance of advisory services. The appointment of the Deputy Administrator of the VA will be by the President with the advice and consent of the Senate. This law also requires a number of studies and reports, mostly concerning medical care facilities, and requires approval of the House and Senate Veterans' Affairs Committees for appropriations to acquire, improve, or lease major VA medical facilities.

Public Law 96-38 - Supplemental Appropriations Act of 1979

A supplemental appropriation of $1,546,723,000 was provided to cover the additional cost of newly legislated veterans' services and benefits.

Public Law 96-86 - Continuing Appropriations for FY 1980

This law continued the appropriations for the Federal government through November 20, 1979. It also authorized the VA to hire 3,800 additional employees into the VA health care system and to expend funds for new medical programs approved in the Veterans' Health Care Amendments of 1979, Public Law 96-22.

Health Care

Comparative Highlights

Item	Fiscal Year		Percent Change
	[redacted]	1978	
Facilities operating at end of year			
Medical centers	[redacted]	172	
Hospital care	[redacted]	(172)	
Outpatient care	[redacted]	(172)	
Nursing home care	[redacted]	(91)	
Domiciliary care	[redacted]	(16)	
Independent or satellite clinics	[redacted]	47	
Independent domiciliaries	[redacted]	1	
Employment (net full-time equivalent)	[redacted]	194,394	−1.6
Operating costs (in millions)	[redacted]	$5,056.4	+7.6
Medical care	[redacted]	4,897.7	+7.7
Research in health care	[redacted]	116.0	−1.4
Other	[redacted]	42.7	+0.8
Inpatients treated	[redacted]	1,342,194	0.0
VA facilities	[redacted]	1,257,701	+0.1
Other facilities	[redacted]	84,493	−1.6
Average daily inpatient census	[redacted]	109,765	−2.7
VA facilities	[redacted]	89,209	−3.6
Other facilities	[redacted]	20,560	+1.1
Outpatient medical visits	[redacted]	17,416,275	−0.8
VA staff	[redacted]	15,069,573	−0.1
Fee-basis	[redacted]	2,346,702	−5.6
Outpatient dental care			
VA staff			
Examinations	[redacted]	127,276	+0.7
Treatment cases completed	[redacted]	127,167	+8.0
Net authorized on fee-basis	[redacted]	110,081	−18.4
Prescriptions dispensed	[redacted]	34,195,884	+4.8
Laboratory procedures (unit count)	[redacted]	183,623,060	+5.0
Radiology examinations	[redacted]	6,074,285	−4.5

Summary

The VA operates the largest centrally-directed health care system in the nation. In 1979, the system was comprised of 172 medical centers, one independent domiciliary, and 49 satellite or independent clinics. All medical centers provided hospital and outpatient care, 92 operated nursing home care units, and 15 operated domiciliaries.

Veterans were also given care under VA auspices in non-VA hospitals and community nursing homes. In addition the VA authorized outpatient visits by veterans to non-VA physicians and dentists on a fee-for-service basis, and supported veterans receiving hospital, nursing home, or domiciliary care in 41 state homes operated by 30 states and the District of Columbia. The VA also furnished medical care to the spouses or children of certain service connected veterans.

During FY 1979, the VA received just over 2.5 million applications for care. Of the 2.4 million applications processed, 84.3 percent were accepted for care (37.8 percent for hospital care, 46.1 percent for ambulatory care, 0.2 percent each for nursing home and domiciliary care). The remaining 15.8 percent were either found not to be in need of care or their applications were cancelled.

Vietnam era veterans accounted for 18.3 percent of the applications processed and veterans 65 years of age or older for 12.6 percent.

During the year, the VA treated about 1.3 million hospital patients, over 48,000 nursing home patients, and more than 27,000 domiciliary patients. Of these, six percent were treated in non-VA facilities.

Outpatient medical care amounted to over 17 million visits – 15 million to VA staff and 2 million to fee-basis physicians. Outpatient dental care reached approximately 128,000 examinations and 135,000 treatment cases completed by VA staff; an additional 90,000 cases were authorized to fee-basis dentists.

The VA provided education and training in the health care field to 86,583 persons, including 23,393 physician residents and interns, and made further advances in research and development with emphasis on rehabilitation engineering.

During FY 1979, the Department of Medicine and Surgery employed 191,168 (full-time equivalent) persons, and operated with a budget of $5.4 billion.

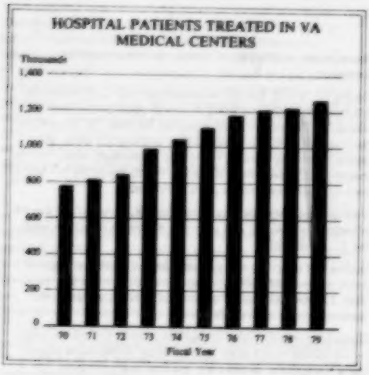
Types Of Care

Hospital Care

At the end of the fiscal year, VA medical centers were operating 85,504 hospital beds – 41,911 in medical bed sections (including extended hospital care beds), 18,218 in surgical bed sections, and 25,375 in psychiatric bed sections. During the year the average bed occupancy rate was 80.4 percent.

The number of hospital patients treated in VA medical centers and in non-VA hospitals during FY 1979 (i.e., the number of discharges and deaths during the year plus the number on the hospital rolls at the end of the year) totaled 1,285,712. Of this number, 1,230,252 were treated in VA medical centers.

The increase in the number of hospital patients treated was accomplished largely by reducing the length of time patients spent in the hospital during an episode of care, thus making beds available for more admissions.



HOSPITAL PATIENTS TREATED IN VA MEDICAL CENTERS

There were 11,000 patients in VA medical centers occupying beds classified as extended hospital care beds during FY 1979. This level of hospital care, which is unique to the VA system, was established in 1964 for providing intensive diagnostic, therapeutic, and rehabilitative services to patients with chronic diseases who are over the acute phase of their illness.

Ambulatory Care

Ambulatory care activities continued to play a central role during FY 1979 in the delivery of health care to VA patients. There were 15.1 million outpatient medical visits provided by VA staff at 227 VA clinics and 2.2 million visits made to private physicians authorized on a fee-for-service basis. These statistics represent a record volume and reflect the growing importance of this level of care.

Outpatient dental care also increased during the year; VA dental services treated 135,000, or 8,000 more outpatients than during the previous year. The 6.3 percent increase resulted from a concerted effort to treat more service connected outpatients by staff rather than by private practitioners on a fee-basis.

A system for provision of routine outpatient services on a priority basis to service connected veterans was successfully installed during the year.

Efforts continued to improve the quality of the physical facilities of VA's outpatient clinics. These involved the completion of construction, renovation, and improvement projects costing over $13 million to expand available outpatient space and improve the flow of patient care services.

Improvements in management of the ambulatory care program were made by expanding the number of positions in the system for Associate Chiefs of Staff for Ambulatory Care and by assigning to the incumbents expanded administrative authority.

An ad hoc committee of VA ambulatory care specialists continued to provide advice on how the ambulatory care program should evolve to meet its future patient care responsibilities. The committee has provided expert comments on several key areas of ambulatory care operations and it is anticipated that it will make additional contributions in the coming years.

Extended Care

VA's efforts in extended care in FY 1979 concentrated on furnishing an adequate number of non-hospital beds either in VA or non-VA facilities, expanding alternatives to institutional care (e.g., home health services), and designing and improving treatment programs particularly suited to the needs of an aging veteran population.

The VA administers several long-term care programs for veterans which are described below.

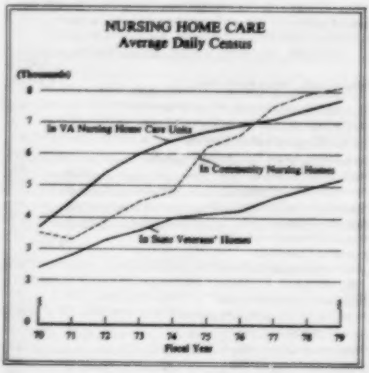
VA Nursing Home Care. The nursing home care units located in VA medical centers provide skilled nursing care and related medical services, as well as opportunities for social, diversional, recreational, and spiritual activities. Nursing home patients typically require a prolonged period of nursing supervision and rehabilitation to attain and maintain optimal function.

A new 60-bed nursing home unit was activated at the VA medical center in Wilmington, Delaware, which brings the total number of units to 92. Also, the nursing home care unit at the VA medical center in Palo Alto, California, was replaced by a new and larger facility.

In FY 1979, over 12,000 veterans were treated in VA nursing homes which had an average daily census of 7,760, and an average operating bed level of 8,206. The average age of the veterans treated during the year was 69.7 years, 60.9 percent were 65 or over, and their attained length of stay was 1,080 days. The trend toward increased provision of nursing home care by the VA is shown in a chart on the following page.

Community Nursing Home Care. This is a contract program to aid veterans who require skilled or intermediate nursing care in making the transition from a hospital to the community. Veterans requiring nursing home care for a service connected condition may be placed indefinitely at VA expense, while nonservice connected veterans may be placed in community facilities at VA expense for a period not to exceed six months. The program requires assessment of participating facilities and follow-up visits to veterans by teams from the VA medical centers.

Nearly 28,000 veterans were treated in over 2,900 community nursing homes in the 50 states and Puerto Rico. The average age of these veterans was 67.9 years; 57.5 percent were 65 or over, and their attained length of stay was 328.6 days. These facilities had an average daily census of



NURSING HOME CARE
Average Daily Census

8,126, and as with VA nursing home units, there was an increase in utilization during FY 1979.

VA Domiciliary Care. Domiciliary care in VA facilities provides necessary medical and other professional care for eligible ambulatory veterans who are disabled by age, disease, or injury and are in need of care but do not require hospitalization or the skilled nursing services of a nursing home.

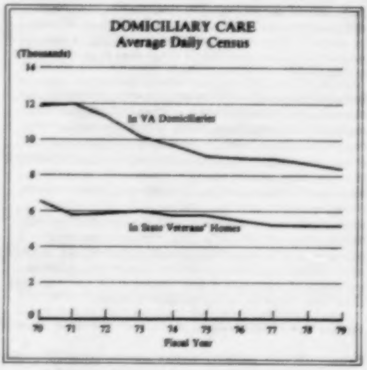
New program directions were developed during the year to create a better quality of life for veterans requiring prolonged domiciliary care and to prepare veterans returning to community living for active participation in various community resources.

Construction was started on replacement domiciliary facilities at the VA medical centers in Dayton, Ohio; Bay Pines, Florida; and Martinsburg, West Virginia. The replacement domiciliary at the VA medical center in Wood, Wisconsin, the first of its kind, was near completion at the end of the year. Plans were developed to evaluate the effect of the change on patient-members from environmental and programmatic perspectives.

In FY 1979 the VA operated 9,485 domiciliary beds, with an average daily census of 8,448. The number of patients treated was 16,541. These figures are consistent with the slowing rate of decline in domiciliary use that began in FY 1976 as shown in the accompanying chart.

State Homes. The VA relationship to state veterans' homes is based on two grant programs. One is a per diem program which enables the VA to assist the state in providing care to veterans eligible for VA care and who are furnished domiciliary, nursing home, or hospital care in state home facilities. The other grant program provides VA assistance with up to 65 percent Federal funding in the construction of new domiciliary and nursing home care facilities, and the expansion, remodeling, or alteration of existing facilities.

The states differ greatly in the availability of facilities they operate for veterans, and therefore, can supplement but not substitute for other VA extended care programs.



DOMICILIARY CARE
Average Daily Census

In FY 1979, new construction resulted in the addition of a 300-bed nursing home care unit at Sandusky, Ohio. In addition, the VA obligated $15.1 million in FY 1979 in support of constructing an additional 580 nursing home care beds and 360 domiciliary beds. A total of 16,207 beds in 42 state homes in 30 states were authorized in FY 1979 to provide hospital, nursing home, and domiciliary care.

During FY 1979, the state veterans' homes maintained an average daily census of 5,203 nursing home, 5,296 domiciliary, and 980 hospital patients. As can be seen in the accompanying charts for nursing home care, the trends are similar to those for the VA facilities. The hospital census has remained stable for many years.

Hospital-Based Home Care. This newest of the VA extended care programs provides for the care of veterans with chronic illnesses in their own homes. A hospital-based treatment team provides medical, nursing, social, dietetic, and rehabilitation regimens, and trains family members in the ongoing care of the patient. Thirty VA medical centers have the capability of providing home health care services. In FY 1979, 148,000 home visits were made by health professionals, and over 5,000 patients were treated.

Personal Care Homes. This program provides personal care and supervision in a home-like community setting for veterans who have no homes or whose homes cannot provide needed care. The veteran pays the sponsor for this care. The number of veterans accommodated in each home ranges from one to 20. Inspection of homes and follow-up services are provided by staff of the VA medical centers.

Geriatric Research, Education and Clinical Centers (GRECC). The GRECC program consists of eight centers and represents another aspect of the response to the health care needs of aging veterans. It serves as a mechanism for attracting and developing superior staff in the field of gerontology and geriatrics, utilizing and redirecting resources for geriatric care, and advancing and integrating into the VA system clinical research and educational achievement in geriatrics and gerontology. The program has been developing geriatric evaluation units, usually of 10 to 30 beds, for intensive diagnosis and therapy. Four GRECCs have instituted evaluation units with a broad base in general internal medicine.

Each center typically emphasizes one area of research; for example, one has developed a cardiopulmonary function evaluation unit, and three others, all with neuropsychiatric orientation, are focusing on chronic neurological diseases and organic dementias. GRECC professionals have published or presented over 250 scientific papers and the centers have reported the award of $3.4 million in research funds since the beginning of the program in FY 1975. Over $1.3 million was awarded from the VA through the merit review process in FY 1979. The GRECCs have also received awards of more than $2 million since FY 1975 from other Federal agencies and private foundations. A formal evaluation of the program was initiated in FY 1979 and site visits were made to four of the eight centers.

Medical Care for Dependents

By the end of FY 1979 there were approximately 221,000 individuals (121,000 adults and 100,000 children) in 129,000 family groups who had established entitlement for medical care under the CHAMPVA (Civilian Health and Medical Programs of the VA) Program. Through this program the VA furnishes medical care to the spouse or child of a veteran who has a total disability, permanent in nature, resulting from a service connected disability, and to the surviving spouse or child of a veteran who died as a result of a service connected disability, or who at the time of death had a total disability, permanent in nature, resulting from a service connected disability.

Since the program began in September 1973, $130.5 million has been expended for hospital care, physician visits and prescriptions, including $39.2 million in FY 1979.

Specialized Medical Services

Specialized Medical Services (SMS) are established to improve quality of patient care with emphasis on satisfying the medical needs of service connected veterans in such vital areas as psychiatric care, rehabilitation, alcohol and drug treatment, aging, and readjustment programs for younger veterans. Specific standards of productivity or utilization are applied to each program, with quality review performed on an ongoing basis. The accompanying table shows the number of units in each Specialized Medical Service at the end of FY 1979.

Clinical and Clinical Support Services

Medicine

Special efforts by VA medical services were made in hypertension, sickle cell anemia, dialysis, rheumatology-immunology, cardiology, pulmonary disease, and intensive care.

Specialized Medical Resources	End of FY 1979
Alcohol Treatment Units	93
Blind Rehabilitation Centers	3
Cardiac Catheterization Centers	67
Drug Dependence Treatment Centers	52
Electron Microscopy Units	45
Hemodialysis Centers	55
Home Dialysis Training Units	53
Satellite Dialysis Units	22
Hospital Based Home Care	30
Intensive Care Units	
No. of Medical Centers	165
No. of Beds	(2329)
Prosthetic Treatment Units	20
Pulmonary Function Laboratories	165
Renal Transplant Centers	18
Respiratory Care Centers	163
Speech Pathology Units	89
Spinal Cord Injury Centers	18
SCI Home Care Units	11
Supervoltage Therapy Units	24

Thirty-two VA medical centers were involved in a pilot hypertension screening and treatment program in which approximately 29 percent of the veterans screened showed elevated blood pressures. There were 30,000 veterans receiving therapeutic intervention in these special clinics and another 23,000 were followed at intervals of 3 weeks to 12 months through this program. Eighty-five percent of the primary care of these veterans is provided by allied health professionals (RNs or Physician Assistants) under the supervision of a physician. A continued decline in the number of strokes and the incidence of heart disease among these patients is believed to be due to the increased control of the hypertensive population.

Forty VA medical centers were participating in a sickle cell screening and education program.* During the year, 48,000 patients were identified and screened, 36,000 persons attended education sessions, and 3,300 people were counseled. The VA film "A Matter of Chance" continued to be shown in various community sickle cell programs as well as in VA medical centers.

The number of patients in the VA dialysis program (including patients dialyzed in non-VA units at VA expense) remained at about 4,200 during FY 1979.

In FY 1979, a large scale Rheumatology-Immunology Center completed its first full year of operation at the Philadelphia VA Medical Center, while a smaller program previously begun at the Wood, Wisconsin, VA Medical Center continued. These centers provide comprehensive, multidisciplinary care to patients suffering from arthritis, rheumatism connective-tissue diseases, and related disorders.

** This information is included in compliance with Section 654, Title 38, U.S.C.*

During FY 1979 cardiac catheterization procedures were performed on 18,287 veterans. The VA, however, is continuing to encourage non-invasive cardiology techniques, such as echocardiology, nuclear cardiology, and stress testing.

Initial steps were taken toward establishing networks of automated electrocardiography for the VA health care system. Networks have been activated in five VA medical districts and others are in the process of being established.

Attention has been given to the growing program of cardiac pacemaker prosthesis implantation in veterans. Since some of the pacemakers may fail unexpectedly, the VA has recognized the need for regular surveillance of pacemaker recipients by establishing surveillance centers and a patient registry.

The program of establishing respiratory care centers at all VA medical centers was nearly completed. There are now over 2,800 designated beds in 163 centers. During 1979, nearly 57,000 veterans received care in these units.

All VA medical centers now have pulmonary function laboratories and 489,000 veterans underwent tests during FY 1979. Many of the laboratories are currently undergoing modernization, which will greatly expand their diagnostic capabilities.

All VA medical centers have been provided with one or more intensive care units. Medical Services at VA facilities utilize nearly 1,400 of these intensive care beds and during FY 1979, 118,000 patients received care. Considerable modernization and expansion of some of the older intensive care units is in progress so that more advanced techniques for critical care can be provided.

Surgery

During FY 1979, there were 362,735 surgical procedures performed in VA medical centers. Studies concerning the supervision of surgical residents, outpatient surgery, preadmission surgical screening, and surgery performed in psychiatric hospitals were initiated. The goal is to reduce the length of stay of surgical patients and improve the quality of care.

During the year, guidelines on supervision of surgical residents were published, preadmission screening of elective surgical cases was emphasized, and VA medical centers were encouraged to establish outpatient surgery programs to reduce the number of patients admitted to hospitals for the performance of minor surgical procedures. Major surgery was phased out of three psychiatric hospitals, leaving only one predominantly psychiatric medical center performing major surgery.

An appraisal of emergency medical services in VA medical centers continued and should be completed during FY 1980.

There was a leveling off of the cardiac surgery workload and a decrease in the organ transplant program. During the year, approximately 5,700 open heart operations and 300 transplantations were performed.

Mental Health and Behavioral Sciences

Mental health services are provided in the VA through the utilization of professionally trained personnel in a multidisciplinary approach to treatment.

On any given day in FY 1979, over 21,000 inpatients received mental health care including chemotherapy and psychotherapy; group, individual, and family therapy; special treatment programs such as behavior modification; incentive work programs; and programs for vocational and educational appraisal for training.

There are 127 VA medical centers with psychiatric bed services. Outpatient services are provided in 100 alcohol dependence treatment programs, 52 drug dependence treatment programs, 41 day hospital programs, 55 day treatment centers, and 136 mental hygiene clinics. In addition, 155 psychology services in VA medical centers and outpatient clinics provide clinical and psychological readjustment counseling, and many centers provide services through biofeedback and relaxation methods for long-term pain problems. Dr. Myron Eisenberg, Chief, Psychology Service, VA Medical Center, Cleveland, Ohio, won the Olin E. Teague Award for his role in rehabilitation, and a major journal is devoting an entire issue to the VA's pain management program.

The accompanying table reflects the continued shift in emphasis toward increasing the number of patients treated while decreasing the number of psychiatric beds.

VA Psychiatric Bed Sections	FY 1979	FY 1969
Operating psychiatric beds at end of fiscal year	25,375	50,129
Average daily census	21,633	43,861
Admissions	159,771	87,150
Average monthly turnover rate	64.2	18.4
Patients treated	188,411	138,814

Since FY 1974, the VA has reduced its psychiatric beds by 5,387, or 21.2 percent, while inpatients treated increased by 3.4 percent. Outpatient mental health program visits numbered 3,039,256 in FY 1979. The Alcohol and Drug Dependence Treatment Programs accounted for an additional 71,000 non-funded visits.

Continued emphasis on outpatient care and rapid intensive treatment, with shorter periods of hospital stay, has resulted in an increase in the numbers of veterans treated by the VA's mental hygiene clinics, day treatment clinics, and day hospitals.

Mental hygiene clinics serve as the basic units in the delivery of ambulatory mental health care. All modalities of sound mental health treatment which might be implemented on an ambulatory basis are utilized in these programs. During FY 1979, 1,156,342 visits were made to mental hygiene clinics.

Day treatment centers provide supportive maintenance and learning environments for patients experiencing long-term difficulties with community adjustment, interpersonal relations, and vocational, educational or behavioral problems. These centers received 506,158 visits from long-term psychiatric patients in FY 1979.

The day hospital programs are ambulatory care programs for patients able and willing to come on a daily basis to receive intensive individual and group therapy. The problems of such veterans are of an acute, intensive or situational nature and can be resolved within a short period of time. During FY 1979, 166,376 visits were made to day hospital programs.

Twenty-one new specialized medical programs for alcoholism treatment were activated in FY 1979. The VA's Alcohol Dependence Treatment Programs emphasize relatively short hospitalization during which comprehensive health and vocational assessment are accomplished by patient and hospital staff. The outpatient clinic continues the veteran's rehabilitation, during which such treatment modalities as group therapy, family therapy, and vocational services are provided. A close collaboration with Alcoholics Anonymous is central to all programs.

The 21 new programs are located at the VA medical centers in Baltimore; Birmingham, Alabama; Boston; Bronx, New York; Charleston, South Carolina; Cincinnati; Cleveland (Wade Park); Dallas; Des Moines; Fresno, California; Gainesville, Florida; Jackson, Mississippi; Kansas City, Missouri; Loma Linda, California; Miami; Montrose, New York; Murfreesboro, Tennessee; New Orleans; Prescott, Arizona; St. Louis (Jefferson Barracks); and San Juan, Puerto Rico. The San Juan VAMC is also planning to activate a specialized medical program for drug dependence treatment.

Plans were formulated to provide halfway house care to alcohol and drug dependent veterans. Approximately 20 sites will be selected and will become operational during FY 1980. Other planning initiatives included the development of several on-campus, VA-operated halfway house programs for treatment of alcohol and drug dependent veterans.

During FY 1979 there were 94,370 inpatients treated for alcoholism, 41,485 of whom were in Alcohol Dependence Treatment Program (ADTP) beds. The average monthly turnover rate in ADTP beds increased from 139.0 percent last year to 142.1 percent in FY 1979. There was a slight increase in the number of outpatient visits for alcohol dependence treatment. Follow-up contacts of former patients for therapeutic/counseling purposes or for assistance with socioeconomic problems increased by 8.8 percent.

During FY 1979, inpatients treated for drug dependence numbered 15,163, and 10,307 of these were in Drug Dependence Treatment Program beds. This was about 14.5 percent less than in FY 1978. The average monthly turnover rate in these beds decreased from 116.1 percent in FY 1978 to 111.8 percent in FY 1979. The total number of outpatient visits for drug dependence treatment decreased slightly in FY 1979.

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A committee was actively concerned with a new treatment setting for psychiatric patients, called "Psychiatric Living Centers." These are specialized living environments providing care, treatment, and rehabilitation services to long-term psychiatric patients who do not need to live in a hospital, but who are not yet ready for successful adaptation to the ambulatory mental health programs.

A special initiative in the Family Mental Health Services program was the establishment of staff positions in 100 VA medical centers to employ fully qualified professionals in Family Systems theory, knowledge, and experience. A total of 32,172 visits were made by veterans and family members for participation in therapy programs. A training conference for 60 family mental health professionals was held with emphasis on developing skills involved in counseling and treatment of family members relating to rehabilitation of the veteran.

During FY 1979, the VA continued to provide vocational counseling services by psychologists. Most VA medical centers employ counseling psychologists and all of the clinical psychologists involved in patient care services assist veterans to reestablish themselves on a personally meaningful and productive level of independent functioning.

Increased liaison relationships were stressed with counseling psychologists of the VA Department of Veterans Benefits, State Vocational Rehabilitation Services, U.S. Employment Office, private employers and other community groups concerned with vocational rehabilitation and placement. Within DM&S facilities, close coordination exists with Rehabilitation Medicine Service, Social Work Service, and such major treatment services as Spinal Cord Injury and Blind Rehabilitation Centers. A special effort which was initiated when Vietnam era veterans first began returning from military service is still continued in VA medical centers. The Psychology Service is informed of each admission of a Vietnam era veteran so that a determination can be made as to the need for vocational evaluations and counseling.

A major Readjustment Counseling Program for veterans of the Vietnam era was in the process of activation. DM&S field facilities were informed of the establishment of the organizacional elements and guidelines for administering this "Operation Outreach" program. The goal is to assist veterans who have failed to make adequate socio-psychologic adjustment and reentry into civilian life by providing counseling to overcome problems and encouraging the use of their veterans' benefits. A Program Director in VA's Central Office will guide field operations through Regional Coordinators who will supervise an initial 86 field outreach teams. The teams are being recruited and supported administratively by parent facilities but housed and operated outside of existing VA facilities. It is expected that 75,000 Vietnam era veterans will be served in FY 1980.

Review and assessment of current physical and psychological health and adjustment problems of former POWs received major emphasis. As part of a VA study of POWs, all available research reports were reviewed and evaluated, and a systematic analysis of the adequacy of medical records of 300 randomly selected POWs from WWII-Europe, WWII-Japan, and the Korean conflict was conducted. A blue-ribbon panel of experts was being assembled to assist DM&S health care professionals to assess the long-range impact of the POW experience on later health and adjustments. Several other steps were also taken including a revision of the VA Admission Form to identify POW status, and reprogramming the VA Patient Treatment File to permit detailed data on POW health problems.

Another major study was underway to determine the number of Vietnam era veterans with unresolved personal, social, and psychological readjustment problems, including those in which excessive use of alcohol or inappropriate use of prescribed drugs and other substances are presenting symptoms requiring medical intervention. The study is also seeking to identify the nature of these problems and the comparative frequency of their occurrence among the Vietnam era veterans and a matched sample of non-veterans. A preliminary report of findings has been submitted to the Congress and the final report will be published in FY 1980.

Policies and procedures were established for periodic review of all patients under psychiatric involuntary commitment in our VA health care facilities. The purpose of such review is to assure that patients are not involuntarily retained when the reasons for their commitment cease to exist.

Rehabilitation Medicine

A significant process was developed during the year to provide for the continuous development, improvement, and delivery of rehabilitation services throughout the VA. This concept was enhanced by two major steps: (1) several studies conducted by both the VA and VA consultants of current programs and recommendations for new directions, and (2) a VA Rehabilitation Conference which reviewed existing rehabilitation programs to develop a comprehensive, systematic, and unified process for medical and vocational rehabilitation.

DM&S developed jointly with the Department of Veterans Benefits the new "case manager" concept. This approach will require new VA policies and procedures to ensure that rehabilitation services are provided in a comprehensive, unified manner on a timely basis. Special emphasis will be placed on bringing the full resources of the VA and the community to bear on the rehabilitation of service disabled veterans receiving, or eligible for, vocational rehabilitation.

The VA's first specialized medical program in Cardiopulmonary Rehabilitation recorded in its initial 18 months of operation 140 referrals and 15,139 visits to a full multidisciplinary treatment milieu. Eighty-two percent of these referrals were veterans over the age of 51; however, many were able to return to their former occupations after receiving the benefits of the rehabilitation program. Future plans at this center include the implementation of training programs for physicians and allied health specialists in this rehabilitation technique.

During the four and one-half years of a formal program in driver training for handicapped persons, the VA maintained a steady number of referrals, training hours, and successful completions. The VA operates 40 driver training centers staffed with trained therapist/instructors and equipped with specially adapted automobiles and vans. Since January 1976, a total of 8,375 veterans have been referred for this training and approximately 38 percent have successfully completed the course and become eligible for state licensing. More than 83,000 hours of training have been provided. This program is recognized by many professionals in the field as a model of driver education for handicapped populations.

The VA operates 51 therapeutic printing plants located in various medical centers around the country for treatment of patients under the rehabilitation medicine program. Many patients have found employment as a direct result of training received in offset printing techniques, and many more patients are considered potentially employable. To expand the scope of patient rehabilitation, silk screen printing equipment and techniques were introduced during FY 1979 in several therapy plants. Knowledge of silk screen techniques increases a patient's employment potential.

Audiology and speech pathology in the VA medical centers is concerned with the most serious forms of communicative disorders, including disabling hearing loss, voicelessness following surgery for cancer of the larynx, and disordered language. Visits for audiology and speech pathology increased to 481,000 in FY 1979, up 20 percent since FY 1975. This growth is associated with the increasing age of veterans since the incidence of communicative disorders rises with age.

The three VA blind rehabilitation centers and three blind rehabilitation clinics (two others were phased out during FY 1979) provided rehabilitation and low vision services to approximately 700 blinded veterans during FY 1979. In addition, 76 visual impairment service teams continued to assist blinded veterans in their home communities, providing services to approximately 4,800 blinded veterans.

All of these programs and the possibility of new rehabilitation programs are being evaluated by a joint Department of Veterans Benefits and Department of Medicine and Surgery Task Force which is developing an agencywide implementation plan for a new coordinated approach to rehabilitation.

Prosthetics

During FY 1979, the VA provided prosthetic services at a cost of nearly $63 million. This included $57 million for new prosthetic appliances and $6 million for repairs to previously issued appliances. An additional $3 million worth of loaned appliances were recovered for reissue to VA beneficiaries.

Efforts continued to reduce the time between prescription and delivery of prosthetic appliances. Prosthetic field representatives from selected VA medical centers assisted in identifying additional areas in which improvement could be made without compromising control. At the end of the year, a test program was underway to permit the direct purchase of stock prosthetic appliances costing up to $500 by eligible veterans. This test program which is being evaluated at nine VA medical centers allows a veteran to take an authorization document directly to a hometown supplier for over-the-counter delivery, eliminating ordering and delivery time. If the results of the test program are favorable, it will be implemented nationwide during FY 1980.

The VA awarded four regional contracts for the purchase of eyeglasses rather than one national contract. This action, together with the direct ordering and mailing procedures implemented last year, should further decrease the time span between prescription and delivery of the eyeglasses to the veteran and provide a more even distribution of the VA workload throughout the country.

Spinal Cord Injury (SCI)

The VA system of specialized care for spinal cord injured veterans is the largest of its kind in the U.S. During FY 1979, over 6,800 patients were treated in VA medical centers. There were 12,000 outpatient visits and 16,000 outpatient home visits made by the SCI Home Care Unit (Hospital-Based Home Care) program team members. There were 1,100 SCI patients admitted to VA medical centers for the first time.

Early transfer and treatment of acute spinal cord injury patients continued to be encouraged. The Armed Services Medical Regulating Office assisted in transferring 86 patients with spinal cord injuries to the VA. Thirteen non-veterans were admitted to a VA medical center within 3 days of injury. Care of non-veterans is authorized as a humanitarian service for spinal cord injury patients who cannot obtain similar care elsewhere. The cost of transportation is borne by non-VA sources.

There are 18 spinal cord injury centers operated by the VA. An additional center at the VA medical center in Augusta, Georgia, will begin operation in 1980 and plans were underway to open two more SCI centers at San Diego and Seattle.

Special spinal cord injury home care units based at 11 SCI centers are serving veterans in their homes. Thirteen of the centers have apartments (Home Environment Clinics) or areas which permit experience in activities of daily living prior to discharge from the medical center.

The VA Medical Center, Long Beach, California, has an active hemodialysis and substance abuse unit which serves only spinal cord injury patients. Also, a hyperbaric chamber was under construction.

Placement of urodynamic laboratories in the spinal cord injury services continued. These special laboratories aid in decreasing urinary tract complications and greatly enhance rehabilitation.

Neurology

A major accomplishment during FY 1979 was the preparation of a manuscript, ''Multiple Sclerosis: Guidelines for Diagnosis and Management.'' Prepared by a panel of national authorities, it is intended to inform the clinician of the latest concepts in the diagnosis and the practical aspects of management of this common, chronic, disabling neurologic disease. The manuscript will be issued as a VA Information Bulletin.

Chronic pain is a major problem which some feel has reached epidemic proportions. A survey of the VA's resources to meet the needs of veterans suffering with chronic pain was completed during the year. The results will serve as the basis for a coordinated network of services.

Epilepsy is a chronic, handicapping condition that affects an estimated one percent of the population (there are an estimated 9,000 veterans with epilepsy in the Los Angeles area alone). Advances in the treatment of this condition are needed and the VA Collaborative Study of Established Antiepileptic Drugs, now entering its third year, is seeking answers to many of the unanswered questions about the optimal clinical use of these drugs. Such answers can be derived only from careful, prolonged observation of a large number of patients. This study, involving the neurology services of 11 VA medical centers, will benefit not only a large number of disabled veterans, but much of the general population as well.

Two additional neurology services were established in FY 1979.

Radiology

VA radiology services encompass the specialties of diagnostic radiology, ultrasound, radiation therapy, and computerized tomographic scanners. Major efforts were made during the year to plan and develop modern and advanced technical X-ray departments for the new VA medical centers at Little Rock, Arkansas; Baltimore; Portland, Oregon; Seattle; Minneapolis; Camden, New Jersey; and Bay Pines, Florida. Updating of X-ray departments was undertaken at the VA medical centers in New Orleans; Tuskegee, Alabama; Reno; Syracuse; Tucson; Phoenix; and Muskogee, Oklahoma. Also, plans to improve space and equipment of many X-ray departments continued, including a continuing study of automated reporting systems which will speed up the availability of X-ray reports for the clinician, thereby reducing the waiting time of patients.

VA radiology continued to be a major supportive and consultative service to other specialties. During the year, it performed 5.9 million examinations of inpatients and outpatients, and processed 17.8 million X-ray films.

In the field of radiation therapy, 24 medical centers offered Cobalt 60, linear accelerator, and betatron supervoltage radiotherapy to patients with deep seated malignancies. Over 15,000 patients received 178,000 treatments at these 24 centers. Elsewhere, radiotherapy was given to patients by transfer to the nearest VA radiotherapy center, or through contractual sharing agreements with a community or university radiotherapy center. Plans were developed for adding supervoltage radiotherapy at the VA Medical Center, Albany.

Nuclear Medicine

During the year the VA nuclear medicine service continued and extended its work of identifying and localizing incipient as well as later stages of disease by employing radioindicators.

With 2.9 million nuclear medicine procedures done for veteran patients during FY 1979, approximately half of all veterans entering any of the 125 VA medical centers with on-site nuclear medicine services had the benefits of these studies. The unit cost of these tests ($10.50) is considerably less than half of their cost in the private sector.

In addition to utilizing amounts of ionizing radiation that are 5 to 10 times smaller than those used by other diagnostic disciplines employing this form of energy, the VA nuclear medicine service implemented procedures to diminish the radiation in which the personnel of a VA medical center work. Thus, personnel in the nuclear medicine service receive less than 10 percent of the Nuclear Regulatory Commission annual maximum of 5 rems.

Because nuclear medicine procedures are non-invasive, they are ideally suited to use in ambulatory care units and nuclear medicine capability in outpatient care increased by 20 to 30 percent during the year.

The teletransmission nuclear medicine computer network originated at the Cochran VA Medical Center in St. Louis, was expanded to incorporate the VA medical center in Amarillo, Texas, and plans were under way to include those in Cheyenne, Wyoming, and Grand Junction, Colorado. This highly cost-effective system brings specialist expertise to remote areas and small medical centers.

Much work was done with the Nuclear Regulatory Commission to implement new regulations pertaining to the use of radioindicators. In addition, a conference on radiopharmaceuticals was co-sponsored with VA's pharmacy service.

Technological advances promising greater diagnostic accuracy with less ionizing radiation were pursued. An emission tomographic system for use with short-lived radioindicators and protons was obtained for the medical center in Madison, Wisconsin.

Exploration into the feasibility and capabilities of non-ionizing devices was made, and two conferences were held on this subject. Off-the-shelf imaging devices are 2 to 3 years in the future, but fundamental in vitro studies can be done now. Similarly, employment of more sensitive, non-ionizing ultrasound instruments continued. Studies on the correlation of these imaging devices and the development of algorithms to achieve great diagnostic specificity without overlapping procedures were inaugurated and pursued.

The Nuclear Medicine Service was intimately and extensively involved in matters pertaining to the 250,000 veterans who participated in nuclear device testing between 1945 and 1962. Medical and scientific opinions, elaborated with the aid of consultants, were rendered on individual claims and before congressional committees. There was extensive work on this subject within the VA and with many other agencies.

Following consultation with the VA medical center at Lebanon, Pennsylvania regarding the implications of and possible courses of action to be taken because of the Three Mile Island Reactor incident, a disaster protocol for VA medical center is under protocol for VA medical centers is under development.

A comprehensive survey of all VA ultrasound activities with costs, equipment, and personnel data was completed and the data were being analyzed.

Dentistry

In anticipation of an increasing number of geriatric patients, emphasis was placed during the year on developing improved dental care models for this group. Meeting the oral health care needs of geriatric patients was also stressed throughout the year in all dental district conferences.

In keeping with the continuing emphasis on timely and relevant education activities for health care professionals, a new West Coast Dental Education Center was established as part of the VA Wadsworth Medical Center in Los Angeles. The VA dental services in the eastern United States will continue to be served by the Dental Education Center located at the VA medical center in Washington, DC.

A study conducted by specialists in the operation of dental laboratories in the private sector was commissioned to enhance the services of the four VA central dental laboratories. Using uniform data as defined and understood in the dental industry, an analysis was made of the cost-effectiveness of the VA laboratories in relation to commercial laboratory costs on a national average. A similar analysis was conducted on each of the VA laboratories with commercial operations in their respective geographical locations.

Legislation extended outpatient dental care to certain veterans who were held as prisoners of war for a period of not less than 6 months, and veterans whose service connected disabilities are rated at 100 percent, or are receiving the 100 percent rate by reason of individual unemployability.

An "Effectiveness Indicator System" continued as a pilot program at five VA medical centers. Electronic programs were developed in preparation for converting these centers to an automated system for testing in FY 1980. The project is intended to provide for better monitoring of patient care and improved measurement of staff productivity.

Optometry

During FY 1979 the new VA optometry service continued to develop and grow. Additional full-time staff were employed.

A pilot program, VICTORS (Vision Impairment Center To Optimize Remaining Sight), was activated at the VA Medical Center, Kansas City, Missouri. This is the first comprehensive interdisciplinary eye clinic to be created within the VA system. It offers complete optometric and medical/surgical care and rehabilitation to eligible veterans requiring corrective lenses for normal vision and for veterans with visual impairments within certain ranges.

The VICTORS program will serve as a prototype for future programs and will also serve as an intermediate link between the visual impairment service teams operating at 72 VA medical centers that identify and counsel legally blind veterans, and the three VA blind rehabilitation centers which rehabilitate veterans who have best corrected visual acuities less than 20/100 and/or restricted visual fields. VICTORS is designed to care for the much larger number of veterans who, while having visual impairments, can quite often resume many of the activities of daily living (such as reading or watching television) through the use of relatively low cost optical or electrical aids and short training periods. Such programs will help upgrade the quality of life for the estimated 500,000 veterans having such visual impairments. The cost of rehabilitation of patients at a VICTORS clinic is approximately one-tenth that of rehabilitation for the more severely visually impaired (legally blind) at a blind rehabilitation center.

Podiatry

During FY 1979 concerted efforts were made to examine the podiatric health needs of the aging veteran through the initiation of an extensive epidemiologic study. The study, conducted in cooperation with the Illinois College of Podiatric Medicine and the Academy of Ambulatory Foot Surgery, was based on 5,510 patient visits to the podiatry clinics of 27 VA medical centers across the country over a four-week period. The study found that the average age of veterans utilizing podiatric services was 57 years, that 70 percent of the patients seen by the VA podiatric service were on an outpatient or ambulatory basis, and that half had service connected disabilities. A significant aspect of this study related to coexisting general medical conditions seen in podiatric patients, for example, podiatric complaints were present in 54 percent of the patients with diabetes mellitus.

Although there were no new podiatrist positions added during FY 1979, an examination of the clinical profile of the total number of podiatrists in the VA demonstrated that the total patient care contact hours per week almost doubled over FY 1978. This was largely the result of the recruitment of 30 new full-time podiatrists into the system two years ago. An analysis of the VA podiatrists by employment status and hours per week is depicted in the accompanying table. It is anticipated that the VA podiatric service will continue to grow.

FY 1979 EMPLOYMENT STATUS OF VA PODIATRISTS

Status	Podiatrists	Hours Per Week
Full-time	44	1,760
Part-time	33	513
Consultants & attendings	98	307
On-station fee basis	10	84
Residents	25	975
Totals	210	3,639

Pathology

VA laboratory services continued to meet the broad requirements of clinical medicine with emphasis on increasing capability to monitor blood levels of certain therapeutic drugs, laboratory assessment of immunological problems, and strengthening of microbiological capability. Increased awareness of the costs of medical care has resulted in focusing attention on the review of laboratory utilization. Selected laboratory data are shown in the accompanying table.

	FY 1979	FY1978	FY 1977
Procedures (unit count)	203,242,806	193,623,053	181,867,305
Workload (unit values)	670,053,272	621,018,860	624,893,174
Deaths	46,048	47,932	51,840
Autopsies	15,975	18,023	17,942
Surgical Accessions	376,899	388,412	380,238
Cytological Accessions	206,449	221,111	220,480

As of October 15, 1979, all 172 VA Laboratory Services enrolled in the College of American Pathologists' Laboratory Inspection and Accreditation Program were accredited.

All VA laboratories participate in survey programs provided by the College of American Pathologists, and those performing tests for syphilis participate in the Special Comprehensive Syphilis Serology Survey. Selected VA laboratories also participate in the Center for Disease Control Proficiency Surveys for Drugs of Abuse and for Drug Overdose and Therapeutic Levels.

The quality assessment program in histopathology developed by the VA in conjunction with the Armed Forces Institute of Pathology (AFIP) entered its second operational year. The program provides a shared review and educational experience in the histopathological diagnosis of cases common in VA medical centers.

The program of the systematic external review of VA autopsies and surgical tissues was in its second year in FY 1979, providing additional continuing education for VA pathologists.

During FY 1979, a special registry was established at the AFIP for pathological material from veterans with possible exposure to herbicides during the Vietnam War. This registry will collect in a central location, over a period of years, pathological materials which may then be integrated with other types of studies, such as clinical laboratory, statistical and epidemiologic, to assist in ascertaining possible long-term effects.

In the same manner plans were initiated to establish a special registry at the AFIP for pathological materials from former prisoners of war in order to make these materials available for the study of the long-term consequences of the prisoner of war experience.

Blood transfusion services in the VA continued to improve. During FY 1979, there were 487,000 units transfused with 98 percent of the blood coming from voluntary donors. Whole blood accounts for about 12 percent of all VA transfusions with the great majority consisting of packed red cells and other blood components. Another accomplishment of the VA blood transfusion program was a low rate (less than 3 percent) of outdating of blood.

The VA continued to introduce new laboratory procedures and improve efficiency and precision. This was done with the acquisition of such equipment as gas chromatographs to assist in identification of anaerobic bacteria, mass spectrometers and high pressure liquid chromatographs to identify unknown drugs and their metabolites, and automated white blood cell differential counters to replace a laborious routine manual procedure.

Nursing

The challenge for the VA nursing service in FY 1979 was to provide safe and effective nursing care while facing increased difficulty in recruiting and retaining adequate numbers of registered nurses (RNs) and licensed practical nurses (LPNs). The mission was met through greater use of part-time employees, by emphasis on increasing the skills and knowledge of the nursing staff, and through a concerted effort to develop and implement standards and guidelines for nursing care.

The problem of recruitment became more widespread in FY 1979. At year's end, all but 15 VA nursing services had RNs on a part-time or intermittent basis, and 34 VA medical centers found it necessary to adjust entry level salaries for RNs. This helped reduce the continuous rotation of full-time nurses to evening and night tours of duty, but was by no means an entire solution to the staffing problem.

Several major factors were identified as having a direct impact on maintaining a qualified staff: heavy workload, increased time lost due to staff illnesses, increasingly acute patient needs; higher patient turnover, specialized medical programs that demand greater use of RNs; rapid technological advances that make nursing more complex, limited support services causing nurses to perform many non-nursing functions, and union agreements negotiated in the private sector which provide higher salaries and better conditions and benefits. Also, commercial nurse-staffing agencies which became popular in California and began spreading to other metropolitan areas, offer nurses many options to work whenever and wherever desired.

In FY 1979, a new Program Guide for infection control was developed to provide standards, rationale, and criteria for establishing and evaluating an infection control program. There are 163 infection control nurses in VA medical centers.

Criteria to evaluate the quality of nursing care were also developed and tested in four diverse health care settings. Refinement and validation of criteria continued at the end of the year.

In another effort to upgrade the quality of VA nursing care, strategies and plans of action were developed for implementing the VA nursing service standards of gerontologic nursing care. The ultimate goal is to implement the standards in all VA medical centers.
Since 1963 when the first position was established for a doctorally prepared nurse researcher, there has been a steady increase in the number of nurses engaged in studies to improve nursing care.

Social Work

Social work continued to focus on the social problems of the chronically ill, the disabled, and the long-term care patient. Increased emphasis was given to insuring that these patients are placed in the most appropriate and least restrictive level of care, and on locating and utilizing alternatives to inpatient care. High priority was placed on finding and developing community resources and supports in a more systematic and formal manner through cooperative agreements and memoranda of understanding. Home health services including core and homemaker services, friendly visiting, transportation for disabled, and meals-on-wheels help reduce the length of hospital stay and are becoming more readily available in the community.

There was significant advancement in the comprehensive rehabilitation of special diagnostic groups with greater emphasis placed on preventing physical and social dysfunctioning of patients with end stage renal disease, cardio-pulmonary conditions, spinal cord injuries, and multiple amputations. These programs are extending rehabilitation to include vocational goals when feasible, and are actively involving the patient more in the plan of treatment.

Maintaining family structures and assisting families to cope with the stress of illness and the dying patient continued to be a major concern of VA Social Work Services.

The development in the VA of a network of community support services to meet the needs of an aging veteran population is consistent with the national focus on outcomes of care for those with mental and physical handicaps. The delineation of quality of life and quality of care criteria by social workers and other health care personnel undergirds the VA's commitment to total health care and fosters the development of appropriate linkages with Federal, state, and community agencies in the pursuit of common objectives. Social workers and other VA staff, along with representatives of key Federal and state agencies and the private sector participated in several regional conferences to address current issues in community programs.

Social Work Service staff developed coordinated plans for the application of program standards and the provision of services at the medical district level.

Pharmacy

A major achievement by VA's pharmacy services involved the conversion to the medication management dispensing system (unit dose) in those medical centers receiving specialized funding support. There are over 20,000 beds on unit dose, representing 41 completed programs and 12 partial conversions. The expected benefits of the unit dose system include reduced medication losses, less probability of medication errors, less diversion of drugs to street traffic, savings in nursing time devoted to medication activities, and a meaningful medication profile on patients.

VA pharmacies continued to fill an increasing number of prescriptions for ambulatory patients. Over 33 million prescriptions were filled in FY 1979, as compared to over 10 million in FY 1970. To process large increases in workload efficiently with a minimum increase in personnel, an on-line computer system is being used by eight VA medical centers. The system prints mail and prescription labels, turnaround documents for refills and renewals, medication profiles, drug utilization reviews, and management reports. It also provides automatic screening of patients' drug regimens for duplications, overlaps, interactions, and allergies. The system will be extended to other facilities in FY 1980, and will be expanded to include inpatient and inventory modules.

The VA actively supported the combined Federal procurement directives in an effort to standardize drug procurement, nomenclature, products description, drug selection, and elimination of duplicate stocked drug items. These procedures are expected to be cost-effective and to reduce the total cost of medications to the VA and other Federal agencies.

The Pharmacy and Therapeutics Committees and the Infectious Disease Committees at each VA medical center implemented criteria for the rational use of anti-infective agents, thereby monitoring the use of all such agents.

Special packaged drugs were being purchased to provide the patient with a ready-to-use prescription container. This not only provides quality assurance, it also is a labor saving procedure helping to keep staffing at a minimum.

Dietetics

During FY 1979, nearly 94 million meals were served in VA health care facilities at a raw food cost of $82.7 million or 88 cents per meal (up from 77 cents in FY 1978).

Approximately 70 percent of the VA dietitians are responsible for direct nutritional care of veteran patients, while the remaining professional staff is assigned to administrative dietetics functions.

Emphasis in the clinical dietetics program was on improved procedures for identifying veteran patients at nutritional risk. The impact of the patients' nutritional status on treatment outcomes has been evidenced in acute medical and surgical patients, and nutritional care intervention has produced significant results in improving patients' response to their prescribed treatment programs. On interdisciplinary nutrition support teams in several VA medical centers, the dietitian is responsible for making comprehensive nutritional assessments of patients and coordinating findings with the physician, nurse, and pharmacist on the team. The special nutrition needs of alcohol or drug dependent patients are addressed through nutrition education programs, particularly in group sessions. The long-term, chronically ill, such as spinal cord injury and geriatric patients require continuing nutritional assessment and care adapted to their changing needs.

The VA dietetic service continues to study the nutritional composition of the daily ration used VA-wide as the basis for menu planning. A proposed revision will be assessed for compliance with currently accepted concepts in nutrition science and for patient satisfaction.

Patient Support Programs

Chaplain Service

The mission of the VA chaplain service is to provide an adequate spiritual and religious ministry for patients in all VA medical centers and for the staff in the medical centers and in Central Office. The VA chaplains function as an integral part of the health care team, representing all major faith groups and denominations and dedicated to the spiritual, physical, and emotional welfare of veterans and their families.

Workshops were conducted during the year on death and dying, aging, how to deal with the alcoholic and his family, involvement with the medical staff and their needs, and a new area of concern for the chaplain service — the orthopedic patient. Chaplains attending the workshops have gained a deeper insight into patients' needs and lives.

The VA chaplain service works with the Church Ecclesiastical Endorsing Agencies of all faith groups to establish rules and guidelines for bringing into the service and nurturing new chaplains for the VA.

Recreation

The VA views broad-based recreational programming as a viable means to improve the quality of patients' lives and to facilitate their reentry into the community. The thrust of VA's recreation services during the year was to support top management in each of VA's health care facilities to meet the human and the clinical needs of patients innovatively.

During the year the VA recreation service developed a new film designed to show how disabled veterans can successfully participate in a multitude of recreation activities, focusing on such qualities as courage, determination, and perseverance.

A life-enrichment pilot program was conducted at the VA medical centers in Perry Point, Maryland, and Salem, Virginia, as a joint effort of the VA chaplain, voluntary, and recreation services. The purpose of the life-enrichment program is to provide an opportunity for veteran patients, who have attained a stable medical condition and mastered the basic activities of daily living, to develop as total persons through a series of recreational and spiritual experiences.

One of the activities of VA's recreation services is to enlist community resources for the welfare and entertainment of VA patients. Some examples of such resources are an artist-in-residence project co-sponsored with the National Endowment for the Arts, and performances under the auspices of the U.S.O. (United Services Organization).

During FY 1979, the VA recreation service utilized over 2.5 million hours of volunteer service with a dollar value over $12 million. The volunteers worked alongside VA recreation therapists to provide seven-day programming, including evenings, weekends and all holidays, for VA patients. In addition, they donated over $1.5 million in cash for recreation supplies and equipment to be used by patients.

Veterans Canteen Service

The Veterans Canteen Service (VCS) operates retail stores and provides food and other service activities at each VA medical center for the comfort and well-being of the patients and members. Canteen retail stores offer patients a wide selection of products for their convenience, entertainment, recreation, hygiene and grooming, and leisure use. Food service facilities provide a convenient source of regular meals and refreshment snacks for patients' families, employees, volunteers, and visitors.

The VCS is by statute an independent, self-supporting organization, financed by revenues generated from its sales. Net income for FY 1979 was $3.2 million which will be utilized in FY 1980 to help offset increased salary costs, the impact of inflation on inventories, and planned canteen improvements. Retail prices are generally maintained uniformly throughout all canteens with the result that some smaller canteens operate at a net loss which is offset at larger, more profitable facilities. VCS is thus able to maintain an overall self-supporting program while providing a uniform level of merchandise and services to all hospitalized veterans.

Improved service to canteen customers was the focal point of VCS activity during FY 1979. Among the more significant accomplishments were completion of a 3-year electronic cash register conversion program, adoption of an integrated nationwide food procurement system, consolidation of the patient and gift coupon books, and major improvements in a number of retail and dining facilities.

Canteens provide gratuitous meals for eligible employees, veterans, volunteers, and other persons throughout the VA medical system. This service was improved during the year with the development of a meal ticket system, which has streamlined the serving line process to the point that it now takes as little time to handle a gratuitous meal as a cash customer.

With the exception of those facilities pending completion of major remodelings, all canteens have been converted to electronic cash registers. This system will utilize detailed "point of sale" information to provide precise and timely sales, inventory, and accounting information. Canteen managers are now able to provide faster service while at the same time using the information provided by the new equipment to utilize their resources better.

The canteens also play an important role in the rehabilitation of patients by providing a welcome break from the hospital environment. Through the canteen's self-selection clothing program many long-term patients are encouraged to become more self-sufficient by taking an active interest in their personal appearance. Canteen coupon books are another important aspect of the VCS's service to patients. They come in many denominations and make ideal gifts for patients. They are also popular prizes in activities sponsored by volunteer groups and service organizations. Over $3 million worth of coupons are used and redeemed by patients each year.

Renovation and remodeling of canteen facilities continued at a high rate during FY 1979. In all, 38 canteen areas (13 food service areas, 17 dining rooms, and eight retail stores) were remodeled. In addition to providing necessary space for new equipment, merchandise, and services, the remodeled areas have improved canteen accessibility for wheelchair and spinal cord injury patients through the removal of architectural barriers.

Building Management

The major functions of the VA building management service include environmental sanitation, a laundry/linen program, and interior design. Interior design received special attention in FY 1979 as an integral part of effective medical center operations because of the potential therapeutic effects. The mission of the VA interior designers is to eliminate drab and disheartening environments, with emphasis this year on the admissions/outpatient and clinical support areas of VA medical centers.

The area of hospital directional signage was also highlighted as a subject of special concern during FY 1979.

Building management service identified a facility most in need of signage improvement in each of the VA's 28 medical districts. The goal was to provide easily readable directional graphics enabling patients and visitors to arrive at their destinations quickly and without confusion. Interior design needs were also identified in a similar manner except that in addition to the first, the second priority interior design project in each VA medical district was also listed. The interior design projects ranged from refurbishing patient waiting rooms at the VA medical center in Baltimore, to installing wall covering in an ambulatory care unit at the VA medical center in Birmingham, Alabama; from remodeling a main lobby at the VA medical center in Hines, Illinois, to renovating an entire floor at the VA medical center in Houston; from refurbishing a psychiatric area at the VA medical center in Waco, Texas; to providing artwork for corridor walls at the Wadsworth VA Medical Center in Los Angeles. A total of $6.3 million was allocated for 84 such signage and interior design projects.

In conjunction with its primary interior design function, building management service acts as liaison to the National Endowment for the Arts for communicating the VA needs in major art acquisitions, and for continuing the enrichment of buildings through the Federal Design program.

Voluntary Service

Major concerns of the VA voluntary service (VAVS) program during the year were the need for additional training of staff and volunteers, the addition of an Associate Membership category to the VAVS National Advisory Committee, and enhancement of communications on a systemwide basis and among member organizations. The service also assumed total responsibility for an annual national event honoring VA patients, "The National Salute to Hospitalized Veterans."

A task force of volunteers and staff was convened for two days of discussion which led to detailed proposals for training of medical facility and national level volunteers, member organization leadership, voluntary service staff, and staff of services to which volunteers are assigned. Implementation of the proposals was underway by the end of the year.

A category of Associate Membership was added to the VAVS National Advisory Committee for organizations active in at least 20 medical facilities but unable to qualify for the Regular Membership category requiring activity at 45 or more facilities. The Forty and Eight organization accepted the first associate membership.

The flow of information between local and national levels of the voluntary service staff and the member organizations was enhanced by refining an automated data processing system which was first installed in FY 1978. The system is providing heretofore unavailable but necessary details of medical facility volunteer programs to the member organizations and to VA's Central Office.

Every VA medical facility participated in the annual "Salute to Hospitalized Veterans," assumed by the VA from the No Greater Love organization which had first established and operated it. The event originated in recognition of Vietnam veterans and broadened later to honor all hospitalized veterans; it is a day of special entertainment and of celebrity and community visits to patients. Activities include events such as concerts, talent shows and dances, and visitations by military personnel, entertainment and broadcast stars, government officials, airline stewardesses, and youth groups (especially the Camp Fire Girls who have adopted the Salute as a national program). The 1979 Salute reached 76,000 patients and involved 6,500 participants from outside the VA.

Maintenance of VA Facilities

During FY 1979, more than 2,228 nonrecurring maintenance and repair projects were approved and obligated for a total of $148 million. Approximately $14 million in personal property funds were expended to support these projects. The following table provides a breakdown of nonrecurring maintenance and repair projects by primary category.

Category	Number of Projects	Cost of Projects (Millions)
Electrical	106	$ 9
Fire and safety	176	10
JCAH deficiencies	42	2
Heating, ventilation and air conditioning	126	8
Boiler plants	64	12
Elevators	49	5
Exterior maintenance	791	28
Exterior utilities	77	6
Interior building maintenance	112	7
Interior utilities	95	5
Quarters	24	0.5
Architectural barriers	67	4
Security	25	2
Energy conservation	102	5
Renovations	324	43
Education	12	1
Research	18	1

Top priority for funding was given to projects for correction of deficiencies identified by the Joint Commission on Accreditation of Hospitals (JCAH) and fire and safety surveys. Energy conservation projects were also given high priority.

Characteristics of VA Patients

The demographic and medical characteristics of VA patients are derived from the Patient Treatment File (discharges occurring during FY 1979) and the Annual Patient Census (taken on September 28, 1979). The data on discharges during FY 1979 excludes approximately 224,590 one-day hemodialysis discharges. Census figures for hospital and domiciliary patients in VA facilities are based on a 20 percent sample; figures for nursing home patients in VA and community facilities are based on a 100 percent survey.

Age

As the veteran's age increases so does the utilization of VA medical centers. This phenomenon is demonstrated in the accompanying table which shows the number of hospital, domiciliary, and nursing home patients discharged during FY 1979 from VA facilities and from community nursing homes.

Age	Veteran Population on 3/31/79 (Thousands)	Hospital Patients Discharged From VA Facilities		Domiciliary Patients Discharged From VA Facilities		Nursing Home Patients Discharged From VA and Community Facilities			
		Number	Rate Per 1,000 Veterans	Number	Rate Per 1,000 Veterans	VA Nursing Home Care Units	Community Nursing Homes	Total	Rate Per 1,000 Veterans
Total	30,072	926,775	30.8	7,382	0.2	3,958	16,025	19,983	0.7
Under 25	1,131	27,655	24.5	28	¹	5	30	35	¹
25-44	11,129	182,100	16.3	700	0.1	124	405	529	¹
45-54	7,436	195,807	26.3	1,889	0.3	407	1,429	1,836	0.2
55-64	7,619	309,598	40.6	2,972	0.4	1,082	4,259	5,341	0.7
65-74	1,964	128,976	65.7	1,231	0.6	902	3,893	4,795	2.4
75-84	570	55,448	97.3	419	0.7	854	3,716	4,570	8.0
85 and over	223	26,661	119.6	143	0.6	584	2,293	2,877	12.9
Unavailable²		839							
Under 65	27,315	715,160	26.2	5,589	0.2	1,618	6,123	7,741	0.3
65 and over	2,757	211,615	76.8	1,793	0.7	2,340	9,902	12,242	4.4

¹Less than 0.1.

²Records for which required data is not available.

A 10-year trend in the age distribution of hospital patients remaining in VA medical centers near the end of the fiscal year is shown in the accompanying table.

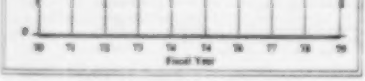
Census Date	Age Distribution of Hospital Patients Remaining in VA Medical Centers					
	Total¹	Under 25	25-44	45-54	55-64	65 & Over
September 28, 1979	69,995	8,071	5,480	14,429	22,754	18,486
October 4, 1978	72,037	8,080	5,887	16,404	23,350	18,714
September 28, 1977	75,067	8,613	6,542	17,870	22,760	18,868
September 29, 1976	78,880	8,421	7,276	19,413	21,804	18,880
October 1, 1975	78,830	9,033	8,440	21,076	20,484	19,311
October 2, 1974	80,715	9,435	8,833	23,053	19,283	19,216
October 3, 1973	82,485	8,870	9,878	24,738	18,377	19,710
October 18, 1972	83,435	9,618	11,006	26,054	17,890	19,345
October 20, 1971	81,150	8,013	10,802	24,802	16,834	20,196
October 14, 1970	85,000	9,013	12,733	27,033	16,038	20,247
October 15, 1969	87,945	7,885	16,158	26,876	15,247	22,270

¹Totals may not equal sum of parts due to rounding

Service Connected and VA Pensioners

Of the hospital discharges from VA medical centers, 48.3 percent were veterans who had a service connected disability or who were in receipt of a VA pension. In FY 1979, the VA health care system continued a leveling off in the proportion of hospital discharges involving veterans who have a service connected condition or who receive a VA pension. A trend for the last 10 years is shown in the accompanying chart.

HOSPITAL PATIENTS WITH A SERVICE CONNECTED CONDITION OR RECEIVING VA PENSION DISCHARGED FROM VA MEDICAL CENTERS FY 1970 — FY 1979



Of the 69,995 hospital patients in VA medical centers on September 28, 1979, 56.3 percent had a service connected disability or were receiving a VA pension. The fact that this is six percent higher than their proportion among discharges illustrates the longer term nature of the service connected patient. The accompanying table indicates the percentage distributions of hospital patients in VA medical centers on the census days of 1975 through 1979, according to their compensation and pension status.

Compensation and Pension Status	Percent Distribution of Hospital Patients in VA Medical Centers on Census Day				
	1979	1978	1977	1976	1975
Receiving care for a service connected disability	17.5	17.0	16.9	16.8	18.2
Receiving care for a non-service connected disability and has a service connected disability which does not require medical care	12.1	11.6	12.4	10.4	9.9
Total service connected	29.6	28.6	29.3	27.2	28.1
Receiving care for a non-service connected disability and on VA pension rolls	26.6	26.5	26.3	27.0	27.6
Receiving care for a non-service connected disability and not on VA compensation or pension rolls	43.4	44.4	43.6	45.3	43.8
Non-veterans	0.4	0.5	0.4	0.5	0.4

Diagnoses

Diagnoses are classified by the VA as either principal or associated. The principal diagnosis is the one that the discharging physician considers to be responsible for the major part of the patient's length of stay. Associated diagnoses are all others for which the patient has been treated up to the time of discharge. The VA statistical system permits the reporting of a maximum of eight diagnoses per patient discharge. Thus, a count of total diagnoses includes the principal diagnosis and up to seven associated diagnoses. As shown on the accompanying table, five major categories accounted for the majority of principal diagnoses among hospital patients discharged from VA medical centers during the past five fiscal years. When both principal and associated diagnoses are considered, and attention is focused on more specific diagnostic categories, the two most common are heart disease and alcoholism, accounting for 24 and 17 percent of the total diagnoses, respectively.

Major categories of principal diagnosis (ICDA 1/)	Percent by Diagnosis of Hospital Patients Discharged from VA Medical Centers				
	FY 1979	FY 1978	FY 1977	FY 1976	FY 1975
Mental disorder	22.6	22.7	22.8	24.0	24.7
Circulatory	15.3	15.3	16.2	15.1	15.0
Neoplasms	10.1	10.0	9.7	9.0	8.4
Digestive	9.2	9.3	9.4	9.5	9.5
Respiratory	6.3	6.5	6.2	6.6	6.6

1/ International Classification of Diseases, Adapted

The number of hospital patients in VA medical centers on the September 28, 1979 census day, by age and major diagnostic category, are shown in the following table. As in previous years, general medical and surgical patients tend to be older (32 percent over 65 years of age), and patients with psychoses tend to be young (18 percent over 65).

Type of Patient	Age Distribution of Hospital Patients in VA Medical Centers on September 26, 1979				
	Total	Under 45	45-54	55-64	65 & Over
All patients 1/	69,955	14,335	14,439	22,764	18,468
General medical & surgical	33,034	3,301	6,068	12,145	10,513
Psychoses	17,769	5,860	4,032	4,798	3,078
Other psychiatric	12,088	3,919	2,705	2,872	2,501
Neurological	7,620	1,208	1,487	2,660	2,244
Tuberculosis	482	38	166	158	130

1/ Figures may not equal sum of component parts due to machine rounding of sample data.

Duration of Stay

There has been a steady decline in the average length of stay of patients discharged from VA hospitals over the past several years; FY 1979 continued that trend with an average length of stay of 29.5 days, down from 30.5 days in FY 1978. Similarly, the median length of stay has decreased from 11.9 days in FY 1978 to 10.9 days in FY 1979. The most notable change was among psychotic patients, where the average length of stay dropped from 104.9 days to 99.1 days in the same time period. Among general medical and surgical patients, who accounted for 69.9 percent of all the FY 1979 discharges, the average length of stay, 19.0 days, was only slightly less than the FY 1978 average of 19.6 days. The accompanying table shows the median length of stay of patients discharged, by type of patient during FY 1977, 1978, and 1979.

Type of Patient	Median Length of Stay of Hospital Patients Discharged From VA Medical Centers (In Days)		
	FY 1979	FY 1978	FY 1977
All patients	10.9	11.3	11.7
General medical & surgical	9.8	10.0	10.4
Psychoses	22.0	23.8	24.9
Other psychiatric	13.5	13.8	13.8
Neurological	13.7	14.2	14.5
Tuberculosis	20.1	21.1	21.7

The complex combination of long- and short-term and acute and chronically ill patients who received VA hospital care means that a single measure of duration of stay, such as average or median, may obscure as well as explain the process. The following observations about length of stay experience in VA hospital beds illustrate the point.

During FY 1979, 83 percent of the almost 927,000 hospital patients discharged from VA medical centers spent 30 days or less in a hospitalized status. Though this group comprised the majority of the discharges, they accounted for only 28 percent of the 27.4 million days of care received since admission by all the discharges. These short-term patients had an average length of hospital stay of less than 10 days. At the other extreme, 0.7 percent of discharges had stays of more than one year and had received 33 percent of all the days of care. Their average length of stay was 1,335 days.

The table below indicates that of the hospital patients remaining in VA medical centers on the census days for the past five years, there has been a gradual increase in the number who have been hospitalized less than 90 days.

Type of Patient	Percent of Hospital Patients in VA Medical Centers With Less Than 90 Days of Attained Stay on Census Day				
	1979	1978	1977	1976	1975
All patients	70.1	69.3	68.0	65.0	64.0
Psychotic	40.2	38.4	38.4	32.6	32.0
General medical & surgical	90.0	88.5	87.5	87.7	87.7

Disposition Status

Of the hospital discharges from VA medical centers in FY 1979 for whom disposition data are available, 88 percent returned to the community. Although this overall percentage has changed little over the past five fiscal years, two of its components have changed considerably. The percentage of patients dicharged for further care as VA outpatients has increased progressively from 58 percent in FY 1975 to 67 percent in FY 1979. Correspondingly, the percent discharged for no further care has decreased from 25.4 to 16.0 in the same period.

As shown in the accompanying table, 7 percent of hospital patients were discharged from VA medical centers for further inpatient care (hospital, domiciliary, or nursing home care) in another VA facility or a community nursing home. Deaths accounted for 5 percent of discharges.

Manner of Disposition	Hospital Discharges from VA Medical Center During FY 1979	
	Number	Percent of Total
Total	919,109[1]	100.0
To community	813,840	88.5
Further care as VA outpatients	616,687	67.1
No further care	147,101	16.0
Irregular, refuse care, neglect or obstruct treatment, AWOL, regulatory offense, etc.	50,052	5.4
To further VA inpatient care	63,284	6.8
Another VA medical center for hospital care	31,623	3.4
Another VA medical center or community nursing home for nursing home care	23,403	2.5
VA facility for domiciliary care	8,258	0.9
Deaths	41,985	4.6

[1] The total number of discharges excludes 7,666 cases with missing data on manner of disposition. Data varies slightly from reports based on all discharges.

Academic Affairs

The VA conducts the largest coordinated health professions education and training effort of its kind in the country. Its purpose is twofold: The first is to assure the highest quality of veterans' health care by educating and training health professionals within the VA's health care delivery system, and providing continuing education and career development for the personnel who manage and direct the operations of VA health care facilities. The second is developing sufficient numbers of all categories of professional and other health personnel to meet the needs of the VA system and, simultaneously, contribute to the health manpower needs of the nation.

VA Facilities-School Affiliations

An integral part of this effort is over 2,000 training relationships between VA health care facilities and schools of medicine, dentistry, nursing, pharmacy, social work, and other allied health professions and occupations at the graduate and undergraduate levels. More than 90 physicians and other senior health professionals are working at the hospital, local community, and regional levels as Associate Chiefs of Staff for Education, Directors of Regional Medical Education Centers, Directors of Cooperative Health Manpower Education Programs, and Patient Health Education Coordinators. These centrally approved representatives are responsible for monitoring existing education and training programs, developing new activities consistent with the needs of their institutions and those in their region, and coordinating these programs with the academically affiliated health professions schools and colleges and in the communities they jointly serve.

The fundamental consideration in the affiliation of VA health care facilities with educational institutions rests on the willingness of all parties involved to cooperate in education and training programs of mutual benefit. Each local VA facility brings its own substantial resources as well as its own expert and extensive staff to this cooperative endeavor. At the national level, the Office of Academic Affairs coordinates these local and regional affiliation activities with the accrediting agencies and the national organizations that represent the various affiliated institutions and professions.

During the year, 137 VA health care facilities and 38 outpatient clinics were affiliated with 105 medical schools, and 88 of these same facilities and 3 outpatient clinics were affiliated with 58 schools of dental medicine. All 172 VA health care facilities were engaged in the education and training of students of all other health care professions and occupations in affiliation with one or more universities, schools, or colleges.

The accompanying table reflects the growth of VA's health care training efforts and the scope of the disciplines involved.

Affiliation Assessment Project

In FY 1979 considerable progress was made in the elaboration of the Affiliation Assessment Project, designed to create more effective management of educational program relationships. The project has gathered, tested, and validated data at nine VA medical center clinical education sites, and in cooperation with affiliated schools of health professions, has tested at eight sites a newly designed method for encapsulating value judgments about affiliations. The basic building block of the computer base for the affiliation assessment system was also completed during the year. Systemwide implementation of the project started on schedule.

Discipline	FY 1979	FY1978	FY 1977
Total	96,583	97,272	95,733
Medical house staff	23,393	22,561	21,123
Medical students	19,392	19,550	18,193
Dental house staff	606	693	595
Dental students	1,086	1,031	852
Nursing	28,968	29,540	31,170
Other associated health professions and occupations	22,300	23,090	22,755
Administrative	838	807	1,045

VA Professional Staff as Academic Faculty

As affiliations with academic health sciences schools and colleges develop and expand, recognition of the academic stature of VA staff is demonstrated in the increased number of faculty appointments. As shown in the accompanying table the number was 8,508 at mid-FY 1979 (as compared to 8,207 a year earlier).

VA Physicians, Dentists, and Other Staff
(Full-time and Part-time)
With Faculty Appointments
March 31, 1979

Academic Title	Total	Physicians	Dentists	Other Staff
Total	8,508	6,459	398	1,651
Professors	1,130	993	16	121
Clinical professors	143	115	14	14
Associate professors	1,312	1,104	38	170
Associate clinical professors	403	319	35	49
Assistant professors	2,695	2,253	81	361
Assistant clinical professors	892	702	89	101
Instructors	847	459	28	360
Clinical instructors	674	327	73	274
Lecturers	82	33	3	46
Other titles	330	154	21	155

Graduate and Undergraduate Medical and Dental Education

During 1979, a total of 125 VA health care facilities participated in 1,473 specialty and subspecialty programs for physicians. Of these, 1,342 were cooperative arrangements between VA facilities and medical schools. Accreditation for 131 other residency programs conducted in VA health care facilities was given in the name of 88 VA facilities and 43 community teaching hospitals with which they are associated, but where there is not medical school affiliation. The majority of these latter programs are sponsored in relatively remote VA facilities.

The VA supported approximately 7,400 full-time residency positions. That total represents about 1/6th of the nation's total number of residents in training. By cooperative affiliation arrangements in the residency program, about three resident physicians are rotated through each supported position in the course of a year. VA hospitals are involved in the education and training of all medical specialties except preventive medicine, obstetrics/gynecology, and pediatrics. Special emphasis is given to supporting programs in primary care and physical medicine and rehabilitation. Through affiliations with medical schools, VA facilities provide clinical education experiences for undergraduate medical students in increasing numbers.

An additional six VA health care facilities were designated as sites for training physicians in geriatric medicine: Buffalo; Durham, North Carolina; Gainesville, Florida; Madison, Wisconsin; Portland, Oregon; and Sepulveda, California. Nine physicians progressed to their second year of training, while 16 began their first of two years in the Geriatric Fellowship Program which is designed to train physicians to more adequately care for the increasing number of veterans age 65 or older.

Two VA hospitals were also designated as sites for the training of physicians in the care of spinal cord injury victims: Long Beach and Palo Alto, California. The three physicians chosen for this program began a two-year fellowship program in spinal cord injury care.

Undergraduate and graduate residency education in dentistry involved 91 VA health care facilities and 305 residency positions in 1979. Clinical clerks as predoctoral dental students also were provided education in the VA system.

Graduate and Undergraduate Education in Nursing and Other Associated Health Professions and Occupations

During 1979, the VA health care system contributed significantly to the education and training of personnel in nearly 50 recognized associated health professions and occupations. The term "associated health" includes all personnel other than physicians, dentists, and medical or dental students engaged in providing direct services to patients. The accompanying table shows the extent of supervised clinical instruction provided in VA health care facilities to nursing and selected other health professions students.

	Participating VA Health Care Facilities	Students Receiving Training
Nursing	155	28,968
Social Work	150	1,097
Psychology	127	1,299
Rehabilitation	112	2,002
Audiology and Speech Pathology	91	758
Dietetics	80	1,098
Physician's Assistant	36	768

For the first time, two VA health care facilities were designated for training geriatric teams: Portland, Oregon, and Sepulveda, California. These sites were chosen in conjunction with the geriatric physician fellowship programs located there. When the health professions function as an interdisciplinary team, it is expected that an elderly veteran will be more likely to receive coordinated and comprehensive care.

Continuing Education and Staff Development

The VA conducts systemwide continuing education programs to bring the latest in scientific, medical, and management knowledge to DM&S employees. These programs utilize all types of training modalities including workshops, seminars, and individual training, and all forms of audiovisual, print, and transmission media. They have three major purposes:

- Instructional design and educational development for all DM&S education activities.
- Executive development and management training.
- Coordination and funding support of the following activities: six Regional Medical Education Centers, the Rehabilitation Engineering Education Program, six Cooperative Health Manpower Education Programs, the Engineering Training Center, the Dental Training Center, and continuing education activities at 172 VA health care facilities.

Instructional Design and Education Development. Particular training emphasis during 1979 was placed on agency priorities including geriatrics/gerontology, substance abuse, rehabilitation and the startup of training for staff of the Readjustment Counseling Program for Veterans of the Vietnam Era (Operation Outreach). Specially designed programs and conferences were developed to strengthen the skills of the health professional in the care of the aging veteran. These activities will provide the basis for an increased number of continuing education programs dealing with geriatrics/gerontology at VA health care facilities.

Executive Development and Management Training. In 1979, over 2,300 DM&S managerial staff attended programs designed to increase management competency, knowledge of broad health care issues, and skills needed to deal with local management issues. This included executive development for 177 senior managers, Office of Personnel Management training for 13 new or advancing managers; residencies for the final seven Graduate Education Program participants; administrative leadership training for 39 social work trainees; university mid-management training specifically developed for 300 VA employees; and 60 local seminars for 1,800 medical center staff. In addition, 208 administrative career entry level trainees received skills training in accounting, building management, engineering, fiscal management, management analysis, medical administration, personnel, and supply; 82 trainees attended basic management training; and 82 service chiefs participated in preceptor training to enhance their teaching skills as these relate to entry level on-the-job training.

Regional Medical Education Centers. The VA Regional Medical Education Centers (RMEC) have become the focus of education and training for VA health care facilities personnel. The RMECs are located at the VA health care facilities in Birmingham, Alabama; St. Louis; Minneapolis; Salt Lake City; Northport, New York; and Long Beach, California.

Each RMEC functions at three levels. At the local level, it works with each individual VA health care facility to assess needs and coordinate programming. At the regional level, it offers programs which are regional in nature or which are difficult for individual hospitals to present. At the national level, it functions as an element of the Central Office Department of Medicine and Surgery.

During FY 1979, a total of 337 training programs were offered by the RMECs involving over 11,000 VA employees.

National Medical Administration Service Training Program. This training program, the largest and most ambitious for an administrative service in the VA, was designed and developed by the RMECs in collaboration with VA's Medical Administration Service (MAS). The program consists of 15 modules (video-cassettes, workbook and Team Leader's Guide) covering the organization and functions of the VA release of information, VA publications, correspondence, medical records, communications, and medical technology. The training program will be used to train over 17,000 employees. By the end of the year, 74 health care facilities had completed the training of their medical administration employees. Upon completion of training for all MAS employees, the MAS National Training Program will be incorporated in a local orientation program for all new MAS employees of the health care facilities.

Other Continuing Education Training Programs. The Rehabilitation Engineering Education Program (REEP) at the Wadsworth VA medical center in Los Angeles, conducted five training programs involving 48 DM&S employees in 1979, and managed the university-based training program in prosthetics/orthotics in which 146 employees were trained. In addition, REEP administered the driver training program during which 77 VA instructors received training in eight workshops.

The Engineering Training Center at the VA medical center in Little Rock, Arkansas, provided 35 workshops for 231 DM&S employees and produced many employee self-study programs.

The Dental Training Center at the VA medical center in Washington, DC, was the hub of dental continuing education activities. During FY 1979, 148 dental personnel received training in current concepts, techniques, and philosophy of dental practice. The Center also produced 20 single-concept films in all aspects of dentistry.

The Continuing Dental Education Registry was fully implemented with 750 dentists participating in the program which requires 150 hours of continuing education over a three-year period.

The VA also supported cooperative health manpower education at the community and area levels through its Cooperative Health Manpower Education Programs (CHEPs). There were six such consortia in FY 1979 assessing the community's needs and the capacity of the local institutions, including VA health care facilities, for meeting these needs through joint action. Support is provided from many public and private resources, including other Federal agencies, educational institutions, private foundations, and community organizations.

Medical Media

Two new medical media services were activated in FY 1979, bringing the current total of VA health care facilities with this specialized activity to 103. Indicators of continued progress are evident with the increasing demand for all types of audiovisual aids. More than 3.5 million work units were reported in FY 1979, including such items as color transparencies, charts and drafts, and motion picture footage.

During FY 1979, the form and function of VA's medical media production services in the field came under intense scrutiny in an attempt to define more clearly their relationship to the clinical care, education, and research missions of the medical centers in which they are located. Particular emphasis was placed on the role of television as a channel for medical communication. Consequently, the evaluation of existing closed circuit television networks and interactive links with medical schools and schools of associated health professions continued throughout the year. Many new insights relating to television's immediacy in this mode, as well as its long-term effectiveness, were identified and were in the process of being assessed for their impact on teaching-learning processes. Much data was gathered to provide answers to questions about the utilization of intramural systems and programming to serve identified needs for support of house staff training, nursing and associated health professions education, and continuing education programs. Field trials and pilot programs were planned which will help to validate the several theses which these studies have generated.

Twenty-three new scientific exhibits and 16 existing exhibits were approved for production and display at national meetings. In addition, two motion pictures and seven videotapes were approved for VA-wide distribution.

Library

Services furnished by the VA Library Network (VALNET) go beyond the traditional library role. The scope of collections held by the 175 VALNET libraries covers the totality of the medical center world with its many disciplines, professions, and health care services.

The libraries of the VA health care facilities are encouraged to establish themselves as the major component of a Learning Resources Center, serving as the information and distribution resource supportive of continuing education, patient education, and training activities. New hospital library space criteria were developed to reflect this orientation.

In an effort to coordinate the use of computer technology to improve services, a contract was awarded to determine the feasibility of automating library network activities. Areas being considered include bibliographic control of materials, library management statistics, production of network tools, and others. Computerized bibliographic data bases are providing the foundation for significant advances in the network's ability to provide agency health care professionals with the most current information possible for use in caring for the veteran patient. In FY 1979, 83 VA hospital libraries had direct access to the National Library of Medicine's Medical Literature Analysis and Retrieval System (MEDLARS) data bases - 16 more than in 1978. Continuing access to the DIALOG system, which provides over 100 separate data bases covering numerous aspects of the physical, life, and behavioral sciences, was furnished to the network through the six libraries at facilities hosting Regional Medical Education Centers (RMECs).

Increased efficiency and cost effectiveness in document delivery is being provided through continuing development of union catalogs listing the holdings and location of print and nonprint materials held by the network libraries. During FY 1979, work continued on a project to provide a VA Union List of Audiovisuals which will contain up to 10,000 separate program titles. In addition, projects were initiated to update the 1978 VA union list of periodicals and to begin production of a new union list of books held by VA libraries. The materials listed in these catalogs are available for sharing throughout the VA and to outside organizations. The catalogs will be produced on microfiche.

Exchange of Medical Information

The Exchange of Medical Information (EMI) Program enables the VA to apply technological advances and new learning modalities to the educational process. This is accomplished by supporting innovative pilot projects which have as their principal objective the strengthening of those VA facilities located remote from urban medical teaching centers.

During FY 1979, 14 EMI projects were supported involving a variety of activities. Included were projects designed to (1) adapt and modify telephonic equipment to provide expanded care to hearing-impaired veterans located remote from medical centers which have audiology clinics; (2) provide the ability to perform computerized axial tomographic scanning at sites located remote from the core equipment by modification of tomographic scanners - thus extending this non-invasive diagnostic technique to more patients; (3) apply adult learning principles to continuing education of health professionals by development testing, and application of appropriate educational standards and criteria; and (4) develop model residency programs in internal medicine and family practice in a medically underserved area remote from the affiliated medical school.

Assistance for Health Manpower Training Institutions

Public Law 92-541 authorizes a program of grants to academic institutions which, in affiliation with VA facilities, conduct programs of education and training in the health professions and occupations. The appropriation authority of this law expired at the end of FY 1979.

Since 1974, when the program was implemented, the VA has provided basic and essential resources for the creation of five new state medical schools to be operated in affiliation with VA health care facilities and other community hospitals, and for major expansion of 18 medical schools with established VA affiliations. These 23 grants involved 32 VA facilities, 19 of which are actively participating in teaching programs for the first time. The 32 facilities are also principally responsible for the appointment of as many as 550 highly qualified full or part-time physicians, and many other health professionals who can combine the challenge and stimulation of teaching with their service to veteran patients. In addition, the VA has made 135 grants expanding and strengthening education and training for other professional and technical personnel in academic programs affiliated with VA facilities.

All five of the new state medical schools are now accredited and have initiated their educational programs with classes of from 24 to 48 students. The 18 other medical schools with established VA affiliations have been assisted in increasing undergraduate enrollments through the grant-supported projects designed for general strengthening of faculty and curriculum, developing new areas of emphasis such as primary care outreach, establishing new clinical campuses, or converting from two-year to four-year degree programs.

The 135 grants that have been made to other health manpower institutions are for one to seven years, and have initiated or enhanced clinical affiliations with 97 VA facilities. Programs in nursing, pharmacy, optometry, social services, and the traditional associated health professions have been funded. Many institutions build programs on resources unique to VA health care facilities, to produce manpower especially prepared to meet needs common to the VA and to the community. Since the program for grants was implemented in 1974, the number of students enrolled in programs receiving grant assistance has increased greatly, and VA health care facilities as well as other health care institutions have been able to hire graduates of these training programs.

Research and Development

The patient care mission of the VA continues to be supported and strengthened in medical centers throughout the country by research and development programs in medicine, rehabilitative engineering, and health services.

Medical Research

Medical Research within the VA is a unique Federal intramural program in which clinician-investigators at VA medical centers study problems arising during the care of veteran patients. Non-clinical scientists in VA medical centers work in close collaboration with clinicians and support their research efforts. This teamwork assures the strongest scientific base for attacking research problems and affords the mechanism for technology transfer by those with first-hand experience and knowledge of the health problems of veterans. Alcoholism, schizophrenia, delayed stress disorders in Vietnam era veterans, loss of limbs, and spinal cord injury are high priority problems in veteran patients. Chronic obstructive lung disease, coronary artery disease, diabetes, and aging are major unsolved problems for veteran and non-veteran patients alike. In this large health care delivery system, good clinical research means high quality care of veteran patients, the recruitment and retention of inquiring clinicians and scientists, and thus significant contributions by the VA to health concerns of all citizens, both veterans and non-veterans.

Awards and Honors. During the fiscal year, VA researchers were recognized at the national and international level with many awards which included the following:

International Awards. Dr. Andrew Schally, Senior Medical Investigator, VA Medical Center, New Orleans, received the National Order of Merit in the grade of Commander from the government of Ecuador in recognition of his contributions to endocrinology in collaboration with Latin American physicians for the benefit of all humanity. Joseph L. Rabinowitz, Ph.D., Chief, Radioisotope Research, VA Medical Center, Philadelphia, and Professor of Biochemistry, University of Pennsylvania, received the degree of Doctor Honoris Causa and a medal from the University of Bordeaux, France. He also received a medal for his research from the University of Nancy, France.

Middleton Award. The VA's highest honor for medical research, the William S. Middleton Award, was given to Dr. Victor Herbert, VA Medical Center, Bronx, New York. Dr. Herbert is internationally known for his contributions to the scientific understanding of the diagnosis of nutrient deficiencies and the metabolism of vitamin B-12 in normal and disease states.

Chief Medical Director Commendation. Dr. Marcus A. Rothschild, Chief of Nuclear Medicine, VA Medical Center, New York, and Professor, New York University Medical Center, received the VA Chief Medical Director's Commendation for his outstanding efforts and accomplishments in the Department of Medicine and Surgery's high priority program of alcoholism research.

Pavlovian Society Award. Dr. Jorge Perez-Cruet, Chief of Psychiatry, VA Medical Center, San Juan, Puerto Rico received the 1979 Pavlovian Society Award, in recognition of his major contributions in the field of psychophysiology and biological psychiatry.

Charles River Prize. Dr. J. Russell Lindsey, Chief of Veterinary Medicine in Medical Research, VA Medical Center, Birmingham, Alabama, received the second annual Charles River Prize for Laboratory Animal Medicine for his distinguished record of contributions to the specialty of laboratory animal medicine science and technology, as a scholarly scientist, an inspirational teacher, and a humanitarian.

Honorary Doctor of Science. Dr. Marguerite T. Hays, VA's Assistant Chief Medical Director for Research and Development, was awarded an Honorary Doctor of Science Degree by Indiana University, in recognition of her achievements as one of the principal medical administrators in the Federal government and her research in the fields of nuclear medicine and endocrinology.

Research Career Scientists. Twenty-six scientists were recognized in FY 1979, bringing to 45 the number of VA scientists who have been awarded the title of Research Career Scientist. This recognition is based on their national and international contributions to medical science as well as their roles in support of the clinical and research programs in their local VA medical centers.

Cooperative Studies - Multi-Hospital Research. VA cooperative studies are multi-hospital investigations in which an important health care problem is studied by investigators at different VA medical centers according to a common protocol. This year, five new studies were undertaken, bringing to 27 the number of investigations in progress. An additional 16 studies were planned, the results of five more were being analyzed, and eight studies were completed. Cooperative studies data resulted in the submission of 22 manuscripts to leading scientific journals.

In a study being conducted at five VA medical centers, 220 diabetic and nondiabetic veteran patients with end-stage renal disease were randomly assigned to peritoneal dialysis or hemodialysis. If chronic peritoneal dialysis proves to be as effective as hemodialysis in improving most of the important biochemical and physiologic parameters of uremia, a huge saving for the VA would result. The patient intake period of the study is nearly completed and the results will be followed for the next 18 months.

A study was initiated to evaluate the merits of two possible forms of therapy for the acute phase of alcoholic hepatitis in veteran patients. It is anticipated that this investigation will not only establish the relative merits and differing actions of these treatment programs, but should greatly advance the knowledge and understanding of the disease and its management. Six VA medical centers are participating in this four-and-a-half-year study.

A study to determine the long-term outcome of veteran patients with valvular heart disease is in progress in 13 VA medical centers. The objectives are to compare two major types of artificial heart valves and to relate the condition of the heart when the valve is inserted to the long-term prospects of the patient. Another double-blind clinical trial at 11 VA facilities is designed to test which of four major anti-epileptic drugs (phenytoin, phenobarbital, primidone or carbamazepine) provides optimal seizure control with least side effects.

Health Services Research and Development

The effective and efficient use of resources has become of paramount concern in the Department of Medicine and Surgery. Health Services Research and Development, which deals with such issues as cost, effectiveness, efficiency, humaneness, and quality of care, is recognized as an integral and necessary component of the effort to meet successfully this concern. Consequently, health services research and development in the VA has entered a new and significant phase with the inclusion of evaluation as an integral part of pilot implementations of two major medical programs. These are a pilot palliative treatment (HOSPICE) program at the Wadsworth VA Medical Center in Los Angeles, and a pilot preventive health care program which the VA was recently authorized to perform. In each of these, a research component, developed as part of the overall plan, will provide not only for evaluation of the medical benefits but also for a cost-effectiveness study to examine the efficiency with which the health care services are delivered.

The health services research and development program of intramural studies continued with VA medical center personnel participating in 45 medical centers. Active affiliations between 14 VA medical centers and university-based health services research centers have been nurtured and strengthened. Funded programs are directed toward improving the delivery of health care to veteran patients. The programs include almost all aspects of patient care, with emphasis on areas of high VA priority such as ambulatory and extended care, rehabilitation, drug and alcohol abuse, and the special problems of the aged.

Management questions have also been addressed. Concern is growing over the management of the ambulatory medical record and the ability of the VA medical centers to have the records available at the times the physicians see the patients. A study was instituted, therefore, to determine: (1) how well the current system performs, and its major problems, (2) the criteria for a good records management system, and (3) what semi-automated and computerized systems are available and appropriate for the VA, and what they cost. A six-month study conducted at five VA medical centers in one medical district showed that the overall performance of the system was good compared to systems in the private sector and that costs for the VA system were less than in the private sector. The biggest single problem identified was lack of adequate space. A second part of the study developed standards for an improved manual system and identified those semi-automated and computerized systems that could be useful to the VA.

Health services research and development has led in developing options for better identifying and serving veteran patients, organizing the delivery system, and allocating resources. A planning model is being developed in one geographic area that incorporates many of the concepts of private sector health maintenance organizations.

Rehabilitative Engineering Research and Development

VA has expanded its program of research and development in devices to assist and support physically disabled veterans.

Prosthetics research is the traditional base for rehabilitative engineering research and development (RER&D) and new program directions recognize the continuing need for prosthetics development, such as lighter weight prostheses for the elderly amputee. The RER&D Service and the Office of the Assistant Chief Medical Director for Professional Services co-sponsored an amputee management workshop in which the latest research techniques, improved diagnostic and surgical procedures, immediate post-operative fitting, and follow-up prosthetic fitting were presented in order to bring the most recent advances into clinical application. The RER&D Service sponsored 20 merit-reviewed projects to solve problems of the amputee. These studies range from endosteal implants for bone extensions to materials analysis on orthopedic appliances implanted in the body. Included are the kinesiology or gait studies for improved ambulation in lower limb amputees. An RER&D sponsored workshop on recent advances in kinesiology transmitted the latest technology to the clinical practitioners.

The problems of the spinal cord injured veteran continued to draw special emphasis. During this year the RER&D Service and the Spinal Cord Injury Service co-sponsored a workshop on spinal cord monitoring. This new technique, to be used during surgical stabilization on the injured spine, allows the surgeon to restore the spinal cord to its natural resting length. Further damage to the cord is prevented once surgical stabilization of the bony spine has been achieved. Eighteen merit-reviewed projects deal with probems of the spinal cord injured patient ranging from such everday problems as pressure sores to improved automotive adaptive equipment for the paralyzed driver. Other projects involve myoelectric control systems for wheelchairs and remote medical manipulators (Robotics) which allow the paralyzed patient to feed himself, answer the telephone, fetch books from a rack, and load paper into a typewriter. This system is intended to give the patient a greater degree of freedom in the simple tasks of daily living.

The sensory aids program received more emphasis during the year. In addition to research at the three VA blind rehabilitation centers and an interagency agreement with the Department of Health, Education, and Welfare for the development of a portable reading machine for the blind, the RER&D Service supported 12 merit-reviewed projects in the sensory aids area. The VA also entered into two interagency agreements with the National Aeronautics and Space Administration. One agreement was to develop wearable devices for automatically cued speech (autocuers). The other agreement was to develop materials for finger cartilage replacement in new techniques for hand surgery. The cued-speech devices bridge the gap between lip reading and American sign language. Using an autocuer, a person who has learned the basic language can quickly learn to lip read since the device removes the ambiguities of speech sounds that look the same when they are formed on the lips.

An RER&D sponsored workshop on maxillofacial prosthetics brought the latest advances of the VA research program into clinical application. Researchers are studying the problems of degenerative joint disease in a unique engineering approach called ferrography, which examines the debris of damaged particles in the synovial fluid of a joint in order to diagnose and evaluate arthritis. The analysis should identify particles causing continued irritation and destruction of the joint. This technique, developed by the Department of Defense to study aircraft engines, is a unique spin-off of advanced technology to solve a medical problem.

Resources

Costs

The operating costs of VA's Department of Medicine and Surgery during FY 1979 were $5.5 billion, an increase of 7.7 percent over FY 1978. The accompanying table summarizes the distribution of these costs by major program.

	Operating Costs (In Thousands)	
Activity	FY 1979	FY 1978
Total Medical Programs	$5,447,958	$5,058,471
Medical Care	5,274,756	4,897,734
Miscellaneous Operating Expenses	46,877	42,715
Medical and Prosthetic Research	126,325	118,022

Increasing workloads are a major factor in the growth of operating costs. Other contributing factors are the rising costs of supplies and materials, and higher costs associated with VA efforts to improve the quality of care. The latter can be demonstrated by the technological cost of procuring and maintaining innovative medical equipment and systems, and of providing the trained work force to utilize these innovations effectively.

The VA strives to deliver the highest quality of care possible and at the same time contain costs by assuring delivery of services through the most appropriate type of care and the most cost-efficient mode. The success of these efforts is evident in the increase in the number of inpatients treated with fewer days of care per patient (with a resultant decrease in the patient census) and in the growth of the ambulatory mode of treatment. The accompanying tables demonstrate these points.

COST EFFECTIVENESS OF INCREASED TURNOVER

Fiscal Year	Per Diem Cost		Cost Per Inpatient Treated	
	Amount	Index (1970 = 100)	Amount	Index (1970 = 100)
1970	$ 38.42	100	$ 1,524	100
1971	43.41	113	1,626	107
1972	52.61	137	1,851	121
1973	57.92	151	1,769	116
1974	65.08	169	1,855	122
1975	75.71	197	1,984	130
1976	87.86	229	2,135	140
1977	103.27	269	2,346	154
1978	119.10	310	2,583	169
1979	133.82	348	2,772	182

The impacts of inflation and technological innovation are difficult to partition, but their overall impact on per diem costs for the major medical care activities are shown in the accompanying table.

Type of Care	Units Costs			Percent Increase
	FY 1979	FY 1978	Change	FY 79 v. FY 78
Hospital Care in VA Medical Centers				
Cost per pat. per day	$ 133.82	$ 119.10	$ + 14.72	+ 12.4
Total Costs (000)	3,410,449	3,173,868	+ 236,581	+ 7.5
Personal Services	2,498,924	2,374,257	+ 124,667	+ 5.3
Other	911,526	799,611	+ 111,915	+ 14.0
Visits to VA Staff				
Cost per visit	$ 56.29	$ 47.13	$ + 9.16	+ 19.4
Total Costs (000)	847,309	710,235	+ 137,074	+ 19.3
Personal Services	521,180	447,178	+ 74,002	+ 16.5
Other	326,128	263,057	+ 63,071	+ 24.0
Domiciliary Care in VA Facilities				
Cost per pat. per day	$ 25.64	$ 23.66	$ + 1.98	+ 8.4
Total Costs (000)	79,084	75,309	+ 3,775	+ 5.0
Personal Services	51,561	50,919	+ 642	+ 1.3
Other	27,504	24,390	+ 3,114	+ 12.8
Nursing Home Care in VA Facilities				
Cost per pat. per day	$ 65.65	$ 62.15	$ + 3.50	+ 5.6
Total Costs (000)	185,965	169,675	+ 16,290	+ 9.6
Personal Services	139,096	129,282	+ 9,814	+ 7.6
Other	46,870	40,394	+ 6,476	+ 16.0

WORKLOAD

Fiscal Year	Inpatient Program				Outpatient Program	
	Average Daily Patient Census		Patients Treated		Staff Visits	
	Number	Index (1970 = 100)	Number	Index (1970 = 100)	Number (In Thous.)	Index (1970 = 100)
1970	85,547	100	787,301	100	6,136	100
1971	84,002	98	818,579	104	6,798	111
1972	80,971	95	846,298	107	7,930	129
1973	82,479	96	985,862	125	9,165	149
1974	81,453	95	1,043,283	133	10,458	170
1975	78,973	92	1,113,873	141	12,596	205
1976	78,264	91	1,178,884	150	14,223	232
1977	75,285	88	1,208,763	154	14,675	239
1978	73,008	85	1,228,755	156	15,070	246
1979	69,871	82	1,230,352	156	15,063	245

Employment

The net full-time equivalent employment (FTEE) in the Department of Medicine and Surgery decreased from 194,294 in FY 1978 to 191,168 in FY 1979. The largest decreases occurred in hospital and outpatient activities, where FTEE decreased from FY 1978 by 2,740 and 505 respectively, as shown in the table below.

Total Health Care: Net Full-Time Equivalent Employment
Fiscal Years 1978-1979

Appropriation/Fund	FY 1979	FY 1978
Total	191,168	194,294
Medical care	181,742	184,911
Inpatient care	153,281	156,152
Hospitals	142,215	144,955
Nursing homes	8,150	8,107
Domiciliaries	2,916	3,090
Outpatient care	26,982	27,487
All other	1,478	1,273
Medical administration and miscellaneous operating expenses	781	777
Research	4,416	4,367
Medical research	4,218	4,182
Rehabilitative research	93	96
Health services research	105	90
Canteen service	3,529	3,495
Supply fund	700	691
Consolidated working fund	...[1]	53

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[1] *Medical Research includes Consolidated Working Fund average employment in FY 1979.*

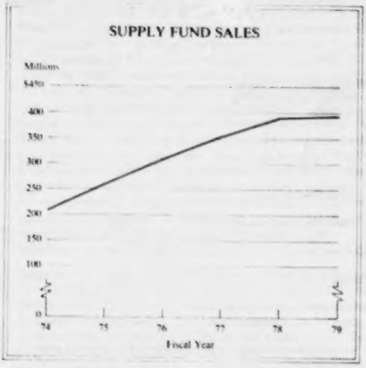
The trend in staffing ratios for major health care activities in VA facilities is shown below.

Fiscal Year	Hospital Care (FTEE/Census)	Outpatient Care (FTEE/1000 Visits)	Nursing Home Care (FTEE/Census)	Domiciliary Care (FTEE/Census)
1970	1.28	1.93	0.87	0.28
1971	1.33	1.93	0.85	0.26
1972	1.46	1.92	0.89	0.28
1973	1.51	1.83	0.90	0.30
1974	1.57	1.73	0.92	0.30
1975	1.66	1.61	0.97	0.30
1976	1.75	1.56	1.00	0.32
1977	1.85	1.63	1.02	0.33
1978	1.95	1.75	1.09	0.35
1979	2.04	1.78	1.05	0.35

Supply

VA renders supply support to the most extensive medical program in the Federal government. A marketing center, three supply depots and 172 supply services in VA medical centers furnish support to about 300 VA installations and about 700 installations of other government agencies throughout the United States, the Republic of the Philippines, and the Commonwealth of Puerto Rico. The annual supply workload for FY 1979 is estimated at $1.5 billion. About $1.1 billion was expended for supplies and equipment for VA activities, $367 million was expended for services, including utilities, equipment rental, and other contractual services, and the remaining $37 million was expended for supplies and equipment for other government agencies.

The VA supply service operates a supply revolving fund, without fiscal year limitation. The fund finances the cost of warehouse inventories at the depots and medical centers which, in major part, have been procured centrally at volume discounts. Annual savings accruing from centralized procurement are in excess of $100 million for the serviced appropriations. Since FY 1974, total supply fund sales have risen $172 million, or 83 percent. The supply fund operated with a net worth of $173 million, and supported an average inventory of $96 million at three depots and 160 medical center warehouses. It also financed direct delivery purchases of $57 million in FY 1979, of which $11 million were for other government agencies. Yearly sales from FY 1974 through FY 1979 are shown on the accompanying chart. The lack of growth of sales in FY 1979 was due mainly to the removal of fuel inventory, which had produced $18.5 million of the sales in FY 1978.


SUPPLY FUND SALES

VA's equipment assets continued to increase in FY 1979 to a new high of $1.2 billion. This is an increase of $150 million during the year, due to continued requirements for state-of-the-art equipment, activation of new medical centers and inflation.

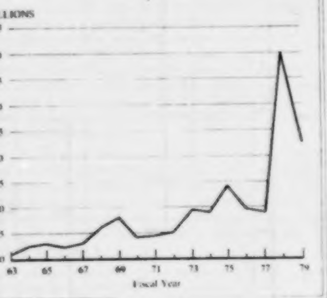
VA EQUIPMENT ASSETS
September 30, 1979

Equipment on Hand	VALUE (Millions)	Percent of Total
Laboratory	$230.4	19.3
Dietetics, housekeeping, and laundry	71.4	6.0
X-Ray	237.2	19.9
Hospital furnishings and equipment	121.1	10.1
Medical, surgical, dental, and optical	213.8	17.9
Office machines	69.8	5.8
Furniture	13.4	1.2
Motor vehicles, tractors, firefighting, etc.	34.1	2.9
Communications	52.9	4.4
Recreational and athletic equipment	12.9	1.1
Maintenance and repair - tools and hardware	4.8	0.4
Refrigeration	16.3	1.4
All other	115.1	9.6
Total	$1,193.2	100.0

Through an effective precious metals recovery program, the VA continued to save money as well as conserve valuable natural resources. Throughout VA medical centers, silver is collected from x-ray processing solutions and scrap medical x-ray film. During FY 1979, over $2.25 million was received from the sale of 209,000 troy ounces of silver bullion and 903,000 pounds of scrap medical film. This money is returned to the VA medical centers through price reduction of centrally produced VA supply depot stock. The chart on the following page shows VA annual gross income from silver bullion and scrap medical film from FY 1963 through FY 1979.

Adequate storage space for medical supplies has been a major problem in VA medical centers for years. New approaches to resolve the storage problem have been sought and during FY 1979 funding was provided to some of the VA medical centers in most critical need for increased storage space to rent commercially available space. In addi-

INCOME FROM VA SILVER RECOVERY PROGRAM



tion, funding was also provided to several facilities for purchase of mobile shelving units which permit better utilization of limited storage space.

In accordance with the statutory labor surplus area (LSA) program to stimulate the economy in high unemployment areas by channeling Federal procurement dollars to those areas, the VA set a FY 1979 goal of $120 million for LSA set-aside contract awards. The achievement was $107 million, or 89 percent of the goal. Although not attaining our goal, the final figures represent a three-fold increase over the LSA set-asides accomplished in FY 1978. VA's ability to achieve its LSA goals for FY 1980 will be enhanced by the Procurement Automated Source System which will enable the VA procuring offices to identify small businesses in labor surplus areas which provide commodities and services needed by the VA.

During FY 1979, the number of interagency cross-servicing support agreements negotiated with other government departments increased from 120 to 190. These agreements included cooperative efforts in all phases of medical and administrative research and development programs, health care delivery, and administrative support including sharing of automatic data processing systems. Cross-servicing arrangements enable the government to share available resources at considerable savings, avoiding overlap and duplication of effort.

In connection with Circular A-76 of the Office of Management and Budget concerning policies for acquiring commercial or industrial products and services for government use, the VA has identified 4,461 activities, encompassing 35,539 VA employees to which the circular could apply. An implementing directive was drafted to provide more definitive guidance to the VA field facilities in the conduct of related studies. The major obstacle that remains to be overcome is adequate training of VA personnel to carry out effectively the requirements of A-76.

Energy Conservation

The VA has continued to reduce significantly the energy required to operate its medical centers. Improvements have been made in the VA's overall Energy Management Program which is designed to exceed the requirements of Executive Order 12003 of a 20 percent reduction in energy consumption from 1975 to 1985. By the end of FY 1979, VA's energy consumption in BTUs per square foot had been reduced nearly 18 percent from the comparable 1975 level of 366,693.

VA research and development in this program in FY 1979 included expanding the solar energy program; conducting research on current energy conservation techniques applicable to hospitals; initiating two studies for possible co-generation installations; developing a computer program for the analysis of energy audit data; initiating construction of a prototype ''heat extractor'' system to recover and use boiler stack energy; planning for two conversions to geothermal energy; converting one hospital from a constant temperature, constant volume heating, ventilating, and air conditioning system to a variable volume, variable temperature system; and revising and improving ventilation standards.

Other accomplishments during the year included the expansion of the energy management data base, the conduct of energy conservation workshops for VA field facility engineers, and the establishment of preliminary energy target goals for each VA field facility.

Quality of Care and Management Improvement

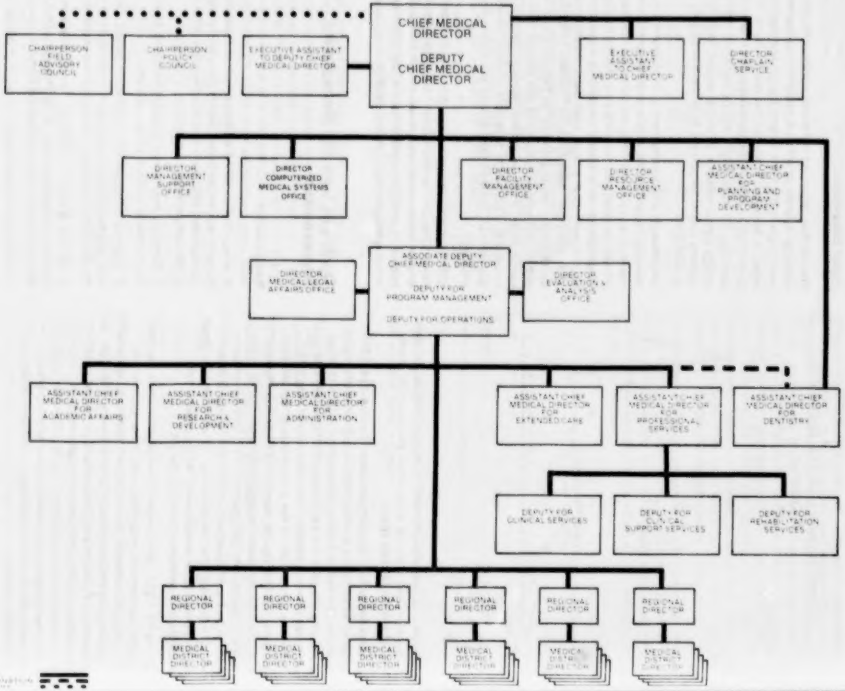
Reorganization

A reorganization of VA's Department of Medicine and Surgery was implemented during the year to improve management efficiency and effectiveness. The major goals of the reorganization were to:

- Eliminate fragmented program functions by consolidating like functions under a single manager.
- Improve communications between DM&S Central Office and field facilities by providing a single point of entry into the Department through creation of six regional offices.
- Reduce spans of control to more manageable proportions through the establishment of an Associate Deputy Chief Medical Director and six Regional Director positions.
- Clearly define and identify levels of decision authority within the Department.
- Elevate and strengthen evaluation of health services delivery and management functions
- Strengthen and expand program planning and development activities to identify more reliably the future health service needs of veterans and to improve the management of new initatives to meet these needs.

The chart on the next page shows the current organization of the Department of Medicine and Surgery.

ORGANIZATION OF THE DEPARTMENT OF MEDICINE AND SURGERY OF THE VETERANS ADMINISTRATION


CHAIRPERSON FIELD ADVISORY COUNCIL
CHAIRPERSON POLICY COUNCIL
EXECUTIVE ASSISTANT TO DEPUTY CHIEF MEDICAL DIRECTOR
CHIEF MEDICAL DIRECTOR
DEPUTY CHIEF MEDICAL DIRECTOR
EXECUTIVE ASSISTANT TO CHIEF MEDICAL DIRECTOR
DIRECTOR CHAPLAIN SERVICE
DIRECTOR MANAGEMENT SUPPORT OFFICE
DIRECTOR COMPUTERIZED MEDICAL SYSTEMS OFFICE
DIRECTOR FACILITY MANAGEMENT OFFICE
DIRECTOR RESOURCE MANAGEMENT OFFICE
ASSISTANT CHIEF MEDICAL DIRECTOR FOR PLANNING AND PROGRAM DEVELOPMENT
DIRECTOR MEDICAL LEGAL AFFAIRS OFFICE
ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR
DEPUTY FOR PROGRAM MANAGEMENT
DEPUTY FOR OPERATIONS
DIRECTOR EVALUATION & ANALYSIS OFFICE
ASSISTANT CHIEF MEDICAL DIRECTOR FOR ACADEMIC AFFAIRS
ASSISTANT CHIEF MEDICAL DIRECTOR FOR RESEARCH & DEVELOPMENT
ASSISTANT CHIEF MEDICAL DIRECTOR FOR ADMINISTRATION
ASSISTANT CHIEF MEDICAL DIRECTOR FOR EXTENDED CARE
ASSISTANT CHIEF MEDICAL DIRECTOR FOR PROFESSIONAL SERVICES
ASSISTANT CHIEF MEDICAL DIRECTOR FOR DENTISTRY
DEPUTY FOR CLINICAL SERVICES
DEPUTY FOR CLINICAL SUPPORT SERVICES
DEPUTY FOR REHABILITATION SERVICES
REGIONAL DIRECTOR
MEDICAL DISTRICT DIRECTOR
REGIONAL DIRECTOR
MEDICAL DISTRICT DIRECTOR
REGIONAL DIRECTOR
MEDICAL DISTRICT DIRECTOR
REGIONAL DIRECTOR
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REGIONAL DIRECTOR
MEDICAL DISTRICT DIRECTOR
REGIONAL DIRECTOR
MEDICAL DISTRICT DIRECTOR
DIRECT
COORDINATION

National Program Planning

FY 1979 witnessed continued commitment by the VA to the principles of national health care planning including coordination with state and community health planning groups. VA representatives sit as members of these local groups and in several instances have been selected to serve in leadership positions. This interaction insures that VA planning efforts are coordinated with the community planning process. In addition, the VA utilizes the notification process of the Office of Management and Budget Circular A-95 to provide another mechanism for inviting the review and comment of local interests.

Sharing of specialized medical resources by VA health care facilities with their community counterparts is an outcome of national program planning. At the end of FY 1979, there were 240 sharing agreements entered by 99 VA medical centers with community health care facilities with a combined annual cost of services received or provided by the VA of $20.2 million.

The VA was instrumental in the establishment of the Federal Health Resources Sharing Committee, an interagency forum in which representatives of Federal agencies interact cooperatively to explore and promote joint planning and sharing opportunities in the delivery of health care services and use of medical resources. The Committee was activated in February 1978. The VA's Assistant Chief Medical Director for Professional Services was the Chairman during FY 1979.

By the end of the year, the Committee had activated 5 subcommittees which were making progress in developing guidelines and criteria for appropriate location of particular specialized medical services, in developing and proposing program utilization standards, and in actively exploring sharing opportunities in specific geographic areas. A number of site visits resulted in specific recommendations for sharing arrangements involving closure of certain units and deferment of planned new units.

Planning for construction and maintenance projects for VA medical centers starts locally with the medical center identifying its own deficiencies and developing a Five-Year Facility Plan of required construction. Some VA facilities are over 50 years old and some buildings were constructed more than 75 years ago. Many now require major construction, alteration, or replacement. Incorporating all major construction projects exceeding $2 million, the plan developed in FY 1979 contains 295 projects with a combined estimated construction cost over $2.8 billion. Studies for improving the utilization of resources and for other management purposes is another aspect of VA's comprehensive plans for strengthening national program planning.

Cost Comparison Study. An acceptable and valid medical care cost comparison methodology and the application of that methodology to the cost of providing care is a high priority effort. This study involves a comparison of short-term inpatient care in the VA with community hospitals and was underway at the end of the year.

Multi-Level Care (MLC) Programs. The VA is evaluating in ten of its 172 medical centers a new system of resource allocation and financial management known as the multi-level care system. The multi-level care program was initiated in the VA in February 1978 in direct response to a number of resource utilization, administrative, and planning needs. As developed in the VA, multi-level care is a refinement of the concept of progressive patient care.

The objective of multi-level care is conceptually simple: to match patients' variable medical needs with different levels of health care resources. One of its basic operational principles is that patients placed at a certain level of care will receive the most appropriate health care resources to meet their needs — neither too much nor too little. Hence, if patients can be matched more appropriately to the resources they need, then the quality of care will be improved while resources will be utilized more cost-effectively.

The multi-level care system comprises two subsystems, the patient care subsystem and the financial management subsystem. By stratifying patients by different levels of care according to their health care needs, and allocating resources appropriately and efficiently to meet these needs, the patient care subsystem is expected to provide information for the following purposes: (1) identification of health care needs of VA medical center population in comparison with health resource requirements among hospitals and districts; (2) development of optimal staffing and resource allocation strategies; and (3) projection of the health care needs of a changing and aging veteran population.

The expected outcomes of the financial management subsystem, which is closely tied to the patient care subsystem, are: (1) average per diem costs by level of care; (2) costs per episode of care; (3) third-party billing capability; (4) cost control mechanisms through resource monitoring; (5) improved medical center resource management mechanisms; and (6) a prospective budgeting system based on patient needs and workload.

Staffing Study. A staffing study was initiated to test existing management engineering-based staffing methodologies for selected services that lend themselves to a work measurement approach. The methodologies will provide a means of measuring approximately 80 percent of the field staff of the Department of Medicine and Surgery. For the remainder of the field staff, professional and technical staffing guides will be developed and tested. Both methodologies will be developed with sufficient sensitivity to reflect the variability that exists among VA medical centers. The product of this study will be the publication of staffing guidelines, by category of personnel, that can be used at any level of management for the planning, budgeting, and allocating of health related manpower. It is also planned to develop a system for monitoring the health manpower resources of each VA medical center.

Space and Functional Deficiency Identification System The pilot development phase of VA's Space and Functional Deficiency Identification (SFDI) System was completed in FY 1979. Evaluation of the pilot phase led to significant modification of the system to reflect more accurately agency priorities (e.g., ambulatory care and patient environment) and expansion of the system to include areas not previously evaluated (e.g., rehabilitation medicine). All VA medical centers were resurveyed utilizing the improved SFDI System. Results of the 1979 survey will assist in the development of future medical center construction budget requests.

Evaluation and Analysis

Health Services Review. FY 1979 was a year of vigorous activity and change for the VA's Health Services Review Organization (HSRO). Improvement was achieved in both the Systematic Internal Review (SIR) and the Systematic External Review Program (SERP). A major contribution to increased effectiveness in HSRO was an alignment of related functions in a new Evaluation and Analysis Office reporting directly to the Associate Deputy Chief Medical Director. This centralization of departmental evaluation responsibilities and its elevation within the VA Central Office structure has enhanced prompt and efficient communication of evaluation findings and provided a foundation to increase the overall cost effectiveness of health care evaluation in the VA. This reorganization was achieved without a net staff increase.

There were 48 SERP surveys completed in FY 1979. The effectiveness of SERP visits was improved through the utilization of experienced highly skilled physicians as SERP consultants. These individuals were selected on the basis of their performance during SERP visits and were recruited to assist SERP team leaders in guiding the team and analyzing data during the visit. In addition, SERP consultants are utilized as advisors regarding external review program developments as the need arises.

The major improvements for SIR have been to develop and conduct a pilot training program for 21 VA medical centers that have appointed Acting HSRO Coordinators. This pilot training program will be expanded to provide education in all VA medical centers in future years. Related to this training there was underway a redefinition and clarification of SIR intended to unify and integrate at the hospital level all health care evaluation activities. Since hospitals are evaluated by more than 40 professional and regulatory agencies, an improved integrated internal review program should improve both the effectiveness and efficiency of the VA health care system. Another related development deals with the development of an improved methodology and guidelines for conducting periodic patient care audits. This "problem focused" audit methodology is undergoing testing at 21 VA medical centers. Comments by both VA and non-VA health care providers indicate clearly that this effort to improve the technology of assessing health care is a marked improvement for the patient care audit process.

Two significant long-range developmental projects, initiated in FY 1978, are beginning to assist the external (SERP) program. One project, Standards, Criteria, Evaluative Algorithms, and Measuring Instruments is intended to provide uniform, valid, objective criteria for external surveyors to use in measuring and judging the quality of health care (direct or indirect) rendered by a particular service. Professionals in each discipline have developed the criteria which, after testing and modification, are furnished to surveyors for use in external reviews. Medical Service criteria are now being used, and those for ten additional services will be in use by August 1980. These are: Surgery, Psychiatry, Nursing, Pharmacy, Dental, Rehabilitation Medicine, Laboratory, Spinal Cord Injury, Psychology and Dietetics. Other services will begin development of criteria in the near future.

The second related project is a Quality Assurance Information System (QAIS), intended to serve as a component in the developing Departmental Health Care Management Information System. QAIS will utilize information from both SIR and SERP to improve the validity, reliability, and usefulness of the wide range of information concerning evaluation of health care. These and other innovative projects are all directed toward providing a cost-effective health care evaluation system for the VA.

Patient Satisfaction Survey. The results of the third biennial survey of patient satisfaction were analyzed and distributed. This survey is structured not only to provide systemwide information but also to provide individual facilities with extensive feedback about their performance, including comparisons with similar patients in similar facilities. Participating were more than 19,000 hospitalized patients and 28,000 clinic patients, selected to be a valid representation of the veteran population for whom VA provides health care. These consumer surveys serve as a management tool useful for local allocation of resources and for taking corrective actions where consumer expectations are not being met.

For the VA system as a whole, satisfaction with services is very high. For most aspects of satisfaction the percentages of positive - that is, favorable - responses, is the 80's, and for some in the 90's. Satisfaction with waiting for care and with the amount of time physicians and nurses spend listening to and talking with patients were at lower levels, and these problems are shared in common with other health care providers. When compared with surveys of satisfaction with health care in the general population conducted by others, it is found that VA patients are generally more satisfied with the care they receive than are patients who receive their care from sources other than VA. Specifically, VA hospitalized patients are considerably more satisfied with their nursing care and food than are other patients, and are somewhat more satisfied with the care provided by their physicians. VA outpatients are somewhat more satisfied with the time they have to spend waiting for treatment and the courtesy of employees than are those in the other-than-VA sector. We have not found any areas where VA patients are significantly less satisfied than are those who receive care from other sources.

Medical-Legal Affairs. During FY 1979, there was a significant increase in claims filed seeking compensation for patient injuries (532 compared with 450 during the previous fiscal year). Nevertheless, this represents a continuation of the VA's recent experience of fewer than 4 claims *made* per 100 physicians. In FY 1978, the figure was 2.54; in FY 1979, it was 3.12. This is considerably below that reported from the non-Federal sector of approximately 6 claims *closed* per 100 physicians.

As a continuation of VA's intensive week-long medical orientation programs for VA attorneys, four additional programs were held during the year in selected teaching hospitals. All areas of the country have been covered and one has had its second program. Current plans call for two of these programs annually so that each area of the country will be covered once in any three-year period. These programs have proven extremely successful in improving working relationships between physicians and attorneys in developing a clearer understanding of the problems faced by professionals in the health care environment.

Copies of the series of the six educational video tape cassettes, entitled "Current Problems in Medicine and the Law," produced by DM&S with the cooperation of General Counsel and co-sponsored by the American College of Legal Medicine, were distributed to each VA health care facility. As a supplement to these tapes, study guides were prepared and will be available for distribution in FY 1980. The study guides and the tapes, augmented by directed discussion, will provide a highly effective method of giving our health care providers timely information on the impact of law on the practice of medicine.

Compensation and Pension

Comperative Highlights

	FISCAL YEAR		Percent Change
	1979	1978	
Cost (billions)	$ 10.5	$ 9.5	+ 10.5
Disability cases on rolls	3,240,283	3,283,120	− 1.3
Service connected	2,266,243	2,258,790	+ 0.3
Non-service connected	973,813	1,024,064	− 4.9
Special acts and retired officers	227	266	− 14.7
Death cases on rolls	1,529,206	1,622,269	− 5.7
Service connected	360,688	362,189	− 0.4
Non-service connected	1,168,499	1,260,061	− 7.3
Special acts	19	20	− 5.0

Summary

Compensation and pension programs administered by the VA fall into five broad categories:

1. Disability Compensation - A veteran is entitled to compensation for disability incurred or aggravated while on active duty. The amount of compensation is based on the degree of disability.

2. DIC and Death Compensation - Dependents of a veteran who died of service connected causes on or after January 1, 1957 are entitled to dependency and indemnity compensation (DIC). Dependents of veterans who died before that date are entitled to death compensation, or may elect to receive DIC.

3. Disability Pension - Veterans who served in time of war are eligible for pension benefits for non-service connected disabilities. The veteran must either be permanently and totally disabled or age 65 or older, and meet specific income limitations. Spanish-American War veterans are entitled to a pension on the basis of their service.

4. Death Pension - The surviving spouse and children of a war veteran who died of non-service connected causes are eligible for death pension benefits, subject to specific income limitations.

5. Burial Allowances - These benefits include a burial allowance, a burial plot allowance and a flag to drape the casket of a deceased veteran. All benefits require separation from the armed service under other than dishonorable conditions. A plot allowance is available in the case of veterans who die of non-service connected disabilities and are not buried in a national cemetery. An award of $1,100 in lieu of basic burial and plot allowances is payable for a veteran who died of a service connected disability.

During FY 1979 the cost of compensation and pension benefits continued to rise, amounting to $10.5 billion in FY 1979, an increase of one billion from last fiscal year. This increased cost is primarily attributable to new legislation which granted cost of living increases and restructured the non-service connected pension program.

Public Law 95-479 (October 18, 1978) increased the rates of disability compensation and DIC by 7.3 percent. This law also resulted in the following changes:

- Additional compensation to veterans who have suffered the loss or loss of use of three extremities.
- A 7.3 percent increase in allowances for dependents, and in benefits for housebound and aid and attendance.
- Reduced the rate of disability required before additional compensation for dependents is payable from 50 to 30 percent.
- A new statutory award of $175 monthly to certain veterans who suffered the non-service connected loss or loss of use of the paired extremity.
- Additional DIC of $45 per month to a surviving spouse who, because of disability, is permanently housebound.
- A second level of aid and attendance benefits for certain catastrophically disabled veterans.
- Increased the annual clothing allowance from $203 to $218.
- Increased non-service connected death burial allowance from $250 to $300, and service connected death benefits from $800 to $1,100.
- Increased Medal of Honor pension from $100 to $200 monthly.

Public Law 95-588 provided for major reform of the non-service connected pension program effective January 1, 1979. One of the principal purposes of the Act was to assure that VA pension benefits are not reduced solely as a result of cost of living increases in social security payments.

The law also assures all veteran pensioners an income above the poverty level by automatically keying pension increases to social security cost of living increases effective the same date. Effective June 1, 1979 improved pension rates were increased by 9.9 percent simultaneously with social security rates.

Maximum annual rate of pension payable is shown in the accompanying table.

	Effective 1/1/79	Effective 6/1/79
Veteran alone	$3,550	$3,902
Veteran with one dependent	$4,651	$5,112
Veteran alone with A&A allowance	$5,680	$6,243
Veteran with 1 dependent with A&A allowance	$6,781	$7,453
Veteran alone, housebound	$4,340	$4,770
Veteran with 1 dependent, housebound	$5,441	$5,980
Surviving spouse alone	$2,379	$2,615
Surviving spouse with 1 child	$3,116	$3,425
Surviving spouse alone with A&A	$3,806	$4,183
Surviving spouse with 1 child and A&A	$4,543	$4,993
Surviving spouse alone, housebound	$2,908	$3,196
Surviving spouse with child, housebound	$3,645	$4,006

This law provided that persons on the pension rolls when the law took effect should choose whether they wish to be covered under the improved pension. Election cards and instructions were mailed to all potential eligibles and the returns were carefully reviewed to determine if the improved pension would be to the advantage of the pensioner. If not, the pensioner was asked to reconsider before the election would be accepted. During FY 1979, almost 500,000 elections were received and about half were placed into the improved pension program.

Public Law 95-476 permits the Administrator to pay a cash amount (limited to $50 in FY 1979) in lieu of a VA provided headstone or marker, as reimbursement for the actual costs incurred by a veteran's survivors in acquiring a headstone or marker to mark the veteran's grave. This act also requires the Administrator to pay $150 allowance to any state, state agency, or political subdivision of a state for expenses incurred in the burial of each veteran in any cemetery owned by such an entity if the cemetery or section thereof is used solely for the interment of veterans.

Compensation

The number of veterans receiving compensation for service connected disabilities increased by 7,453 during FY 1979. This was primarily because of an increase of 18,066 Vietnam era and 17,864 peacetime veterans receiving this benefit. World War I and World War II cases showed substantial declines of 3,949 and 23,266 respectively; Korean conflict cases dropped by 1,362.

Service connected death cases showed a net decrease of 1,501 during FY 1979 with declines recorded for all periods of service except the Korean conflict, Vietnam era, and peacetime which together increased 1,829 cases.

Pension

The number of veterans on the pension rolls decreased 50,253 or 5 percent in FY 1979 following a smaller decrease of 7,083 in FY 1978. A decrease of 44,086 World War I pensioners, 9,554 World War II pensioners and 131 old war veterans was not offset by 3,518 pensioners added to the rolls from the Korean conflict and the Vietnam era.

The death pension program shows a total decrease of 91,562 or 7 percent in all eight periods of service. Of the total, 41,117 were from World War I cases, 36,864 from World War II, and 10,777 from the Korean conflict. Decreases in pension claims ranged in FY 1979 from a low of 3 percent of Vietnam era death pension claims to 12.7 percent of Civil War death pensioners.

Period of Service

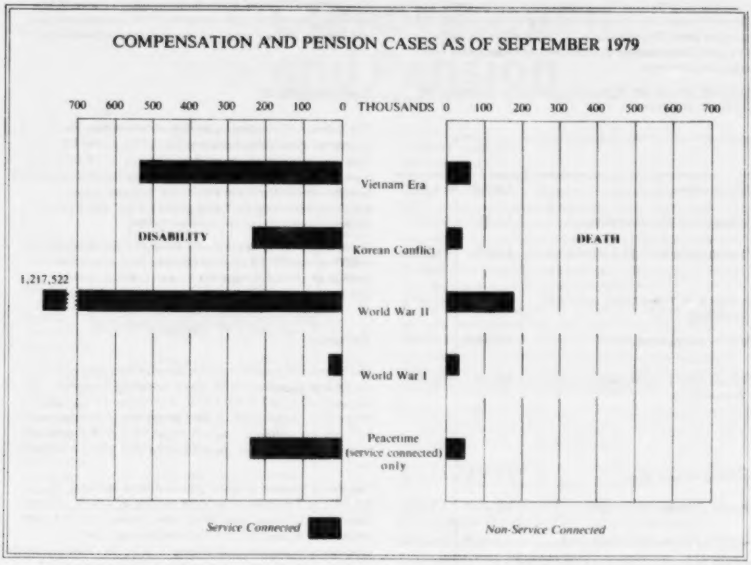
Vietnam Era

There were 18,066 more Vietnam era veterans receiving compensation at the end of FY 1979 than at the end of FY 1978. The accompanying chart shows the general trend in new Vietnam era cases. The chart also shows that the total number of Vietnam era veterans receiving compensation continues to increase and, with new cases exceeding losses, this trend is expected to continue.

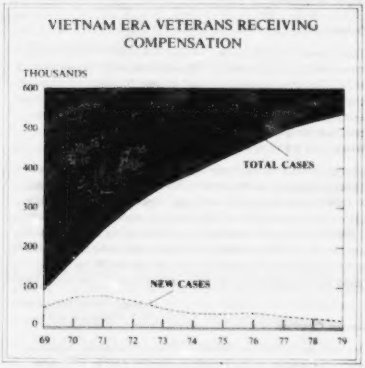
A total of 15,210 Vietnam era veterans were receiving disability pension at the end of the fiscal year, an increase of 1,069 or 8 percent over a year ago. Since the average age of these veterans is 33 years, no appreciable increase in those applying for disability pension is expected. The number of service connected death cases was up 2 percent to 64,076 while non-service connected death pension cases fell 3 percent to 28,891 at the end of the fiscal year.

Korean Conflict

The number of Korean conflict veterans receiving compensation decreased to 237,102 during FY 1979, the sixth



COMPENSATION AND PENSION CASES AS OF SEPTEMBER 1979



VIETNAM ERA VETERANS RECEIVING COMPENSATION

consecutive drop in that figure. The high mark on the rolls was reached in June 1973 at 240,765, 18 years after that conflict ended. For comparison, the highest number of World War II veterans receiving compensation was in FY 1953, only 8 years after the end of the war.

In contrast, the number of Korean conflict veterans receiving pension continues to rise. At the end of the fiscal year there were 80,286 Korean conflict veterans on the pension rolls, a 3 percent increase over FY 1978. As this group grows older the number on the pension rolls can be expected to increase. The number of service connected death cases remained virtually the same at the end of the fiscal year, and the number of death pension cases decreased 10 percent.

World War II

Veterans of World War II still constitute the largest single group receiving compensation for service connected disabilities, though their numbers continued to decline (2 percent in FY 1979). Non-service connected pension showed a 1.4 percent decrease to 681,493 cases. Service connected death cases declined by 2,655 cases or 1.5 percent in FY 1979. The non-service connected death pension caseload decreased 36,864 to 531,716, a 6.5 percent decline in FY 1979.

World War I

The number of World War I veterans receiving disability compensation declined during the past fiscal year about 10 percent. World War I disability pensions also decreased (18 percent in the past fiscal year). The advanced age of this group of veterans will accelerate these decreases in the next few years. Decreases were also recorded for service connected death cases (2 percent) and death pension cases (8 percent).

Other Periods

In addition to the recipients of disability compensation and pension payments from the wars and armed conflicts cited above, three veterans of the Spanish American War were receiving disability compensation as of September 30, 1979, and 206 were receiving disability pension. This latter figure is down from FY 1978 by nearly 30 percent. The service connected death and death pension caseloads were 151 and 14,786 respectively. In FY 1979, five veterans of the Mexican Border Service were receiving disability compensation and 215 were disability pensioners, down 44 from last fiscal year. There were three service connected death cases from this period while the death pension cases decreased 8 percent to 560. While there are no living veterans of the Indian War and the Civil War, one helpless child is receiving service connected death benefits as an Indian War beneficiary and 48 widows and 10 helpless children are receiving death pension benefits. Three widows and three helpless children receive service connected death benefits with Civil War entitlement and 87 widows and 127 helpless children receive death pension. The number of peacetime veterans receiving compensation as of September 30, 1979, increased 8 percent over the previous year. Beneficiaries of deceased peacetime veterans increased 485 to 49,188 in FY 1979.

Benefit Overview

The accompanying tables present a detailed picture of the compensation and pension programs, showing the number and percent of all current cases for each period of service and a comparison with FY 1978.

Period of Service	Disability Compensation Cases					
	FY 1979		FY 1978		Change	
	Cases	Percent of Total	Cases	Percent of Total	Number	Percent
World War I	34,217	1.5	[illegible]	[illegible]	[illegible]	[illegible]
World War II	1,211,522	[illegible]	1,240,789	[illegible]	[illegible]	1.9
Korean conflict	241,102	10.5	236,484	[illegible]	[illegible]	[illegible]
Vietnam era	541,208	23.7	519,342	23.3	[illegible]	[illegible]
Peacetime	240,186	10.9	222,272	9.8	17,864	8.1
Spanish American	3	*	3	*	[illegible]	
Mexican Border	5	*	5	*	[illegible]	
Total	2,296,243	100.0	2,288,790	100.0	[illegible]	0.3

*Less than 0.1 percent

Overall the number of disability compensation cases increased only 0.3 percent from FY 1978 to FY 1979 and World War II veterans accounted for over half of the total. Vietnam era veterans were the next largest group with 23.7 percent, while World War I veterans were only 1.5 percent of the compensation caseload. Korean conflict and peacetime veterans each accounted for about 11 percent. Vietnam and peacetime service veterans increased while all other periods of service decreased. In FY 1979 the overall increase of 7,453 was smaller than the 11,475 increase recorded in FY 1978.

Period of Service	Disability Pension Cases					
	FY 1979		FY 1978		Change	
	Cases	Percent of Total	Cases	Percent of Total	Number	Percent
World War I	196,423	20.2	240,509	23.5	44,086	18.3
World War II	681,493	70.0	691,047	67.5	9,554	1.4
Korean conflict	80,266	8.2	77,817	7.6	+ 2,449	+ 3.2
Vietnam era	15,210	1.6	14,141	1.4	+ 1,069	+ 7.6
Spanish American	206	*	293	*	87	29.7
Mexican Border	215	*	259	*	44	17.0
Total	973,813	100.0	1,024,066	100.0	50,253	4.9

*Less than 0.1 percent

Disability pension cases decreased in FY 1979, despite an increase of 3,518 cases from the Korean conflict and the Vietnam era. All other periods showed a decline in numbers. Losses from among World War I, World War II, Spanish-American War, and Mexican Border veterans totaled 53,771 resulting in a net decrease. World War II veterans make up over two-thirds of the pension rolls, with World War I veterans accounting for another 20 percent.

Period of Service	Service Connected Death Cases					
	FY 1979		FY 1978		Change	
	Cases	Percent of Total	Cases	Percent of Total	Number	Percent
World War I	31,284	[illegible]	31,949	8.8	665	2.1
World War II	176,742	[illegible]	179,397	49.5	2,655	1.5
Korean conflict	39,237	10.9	39,235	10.9	2	*
Vietnam era	64,116	17.8	62,734	17.3	+ 1,382	2.2
Peacetime	49,188	13.6	48,703	13.5	+ 485	1.0
Spanish American	151	*	162	*	11	6.8
Mexican Border	3	*	3	*	0	
Indian War	1	*	1	*	0	
Civil War	6	*	5	*	+ 1	20.0
Total	360,698	100.0	362,189	100.0	1,491	0.4

*Less than 0.1 percent

For the third straight year there has been a decline (0.4 percent in FY 1979) in the number of service connected death cases for which payments are made to dependents of deceased veterans. World War II represents nearly half of all cases, with Vietnam era cases next at 17.7 percent. Vietnam era, Korean conflict, and peacetime cases were the only ones to show an increase over the previous year.

Period of Service	Death Pension Cases					
	FY 1979		FY 1978		Change	
	Cases	Percent of Total	Cases	Percent of Total	Number	Percent
World War I	482,171	42.1	533,288	43.1	-51,117	-9.6
World War II	521,718	45.5	558,602	45.1	-36,884	-6.6
Korean conflict	98,113	8.5	108,890	8.8	-10,777	-9.9
Vietnam era	28,881	2.5	29,774	2.4	-893	-3.0
Spanish-American	14,786	1.3	16,621	1.3	-1,835	-11.0
Mexican Border	680	*	740	*	-60	-8.1
Indian War	48	*	54	*	-6	-11.1
Civil War	214	*	244	*	-30	-12.3
Total	1,146,499	100.0	1,238,081	100.0	-91,582	-7.3

*Less than 0.1 percent

In FY 1979 death pension cases showed a considerably larger decrease than in the previous year (7.3 percent vs. 0.6 percent). For the first time all periods of service reflected a decrease and the largest decline in numbers occurred among World War I and World War II survivors.

World Wars I and II each account for over 40 percent of death pension cases, while survivors of Vietnam era veterans are only 2.5 percent of the file.

Burial Allowance

Statutory burial allowances are designed to assist in providing a respectable burial for a deceased veteran separated from the armed service under other than dishonorable conditions. The allowance is payable for a veteran who was separated from wartime service. It is also payable in the case of a peacetime veteran discharged or retired for a disability incurred in or aggravated by service in line of duty or a veteran who was in receipt of compensation for a service connected disability.

Generally the VA will pay a sum not exceeding $300 (plus transportation charges where deaths occur under VA care or while entitled to disability compensation) to help cover the burial and funeral expenses. An additional allowance of $150 for a burial plot where a veteran is not buried in a National Cemetery is also payable. An award of $1,100 in lieu of these basic allowances is authorized for an eligible veteran who died of a service connected disability.

In FY 1979 basic burial allowance was paid for 313,651 claims in an amount in excess of $94.2 million. Cemetery plot allowances totaling over $41 million were paid to 283,454 claimants. Service connected burial benefits amounting to $8.7 million were paid to 10,247 claimants. This year a total of 296,117 burial flags were issued, an increase of 3.5 percent from FY 1978. The cost of each flag was $15.47, making a total of $4.6 million.

Education Benefits

Comparative Highlights

Item	FY 1979	FY 1978	Percent Change
Education benefit costs (millions)	$2,751	$3,344	-17.7
Post-Korean trainees	1,278,538	1,521,840	-16.0
Post-Vietnam trainees	456	37	+1,132.4
Sons and daughters	65,898	68,259	-2.9
Spouses	17,280	19,394	-11.0
Vocational rehabilitation trainees	29,470	31,018	-5.0
Beneficiaries counseled	119,840	130,258	-8.0

Summary

Education benefits administered by the VA include educational assistance for veterans and service personnel, commonly termed the "GI Bill"; vocational rehabilitation for service disabled veterans; dependents' educational assistance for eligible spouses and children of veterans who died of service connected causes, whose service connected disability is rated permanent and total, or who are missing in action or prisoners of war for more than 90 days; and Post-Vietnam Era Veterans' Education Assistance for veterans and servicepersons entering active duty after December 31, 1976.

Other education benefits administered include payments to eligible veterans to aid in defraying the expenses of tutoring, a work-study program permitting eligible veterans to perform services for the VA in return for a monetary allowance, and an education loan program for veterans or other eligible persons enrolled in approved educational institutions at least half-time.

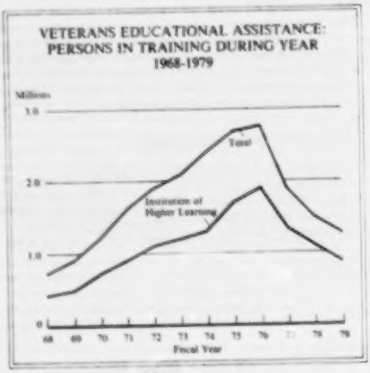
Education and Training

Veterans Educational Assistance (GI Bill)

Nearly 1.3 million veterans and active duty personnel received educational benefits in FY 1979 under the Post-Korean GI Bill. This figure is down 16 percent from FY 1978, and is expected to continue its decline in coming years.

Veterans and service personnel who have not completed high school nor received an equivalency certificate are considered to be educationally disadvantaged and may, without charge to their basic entitlement, receive training to overcome their educational handicaps. As of the end of September 1979, over 823,000 veterans and servicepersons had participated in these "free entitlement" programs since Public Law 91-219 became effective in March 1970.

Through September 1979, the total number of veterans trained under the current GI bill topped 7.6 million, of whom 71 percent have been Vietnam era veterans. More than half have trained at the college level (excluding correspondence); the remainder are divided among other residence training, correspondence training, and on-the-job training.



VETERANS EDUCATIONAL ASSISTANCE:
PERSONS IN TRAINING DURING YEAR
1968-1979

At year's end the participation rate was 65 percent among Vietnam era veterans and servicepersons, and 57 percent for Vietnam era veterans only. This compares to 51 percent for veterans who trained under the World War II program.

At the end of FY 1979, cumulative expenditures on Veterans Educational Assistance for Post-Korean conflict trainees exceeded $30 billion, compared to $4.5 billion for the Korean conflict program and $14.5 billion for the World War II program.

Through the veteran student services program (work-study) in FY 1979, the VA paid for over 7 million hours of work by veterans enrolled under veterans' educational assistance or vocational rehabilitation. Services were performed at VA regional offices, schools, hospitals, cemeteries, or other designated sites.

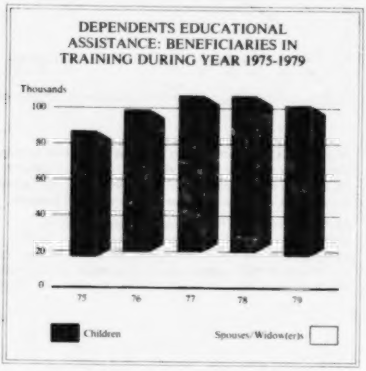
About 11,000 education loans were granted compared to nearly 29,000 the year before. Costs declined from over $57 million to approximately $8 million due to more stringent eligibility requirements. The average loan amount has declined because the loan period is limited to one term, quarter, or semester rather than a full school year, as before. Public Law 95-476 limits the program to loans for attendance at high-cost schools and shortens the repayment period. The high rate of defaults (over 50 percent at year's end) continues to be a problem as an increasing number of loans granted earlier in the program reach maturity; however, program changes designed to diminish the problem will be reflected as loans granted after FY 1978 mature.

Post-Vietnam Era Veterans' Educational Assistance

At the end of FY 1979 there were over 100,000 active participants (in-service contributors) in the Post-Vietnam Era Veterans' Assistance fund. The number of trainees during FY 1979 (456) was considerably lower than estimated at the beginning of the program. The program is under continuing review by both the VA and the Department of Defense who prepare a joint annual progress report.

Dependents' Educational Assistance

This program provides educational assistance for survivors of veterans who died from service connected causes and for dependents of veterans whose service connected disabilities are rated total and permanent. Spouses and children of service personnel who are prisoners of war, missing in action, or interned by a foreign government for more than 90 days are also eligible under this program. Up to 45 months of full-time training is provided in approved schools. Over 85,000 children and 17,000 spouses took advantage of the program during FY 1979; nearly 90 percent used their entitlement to acquire college level training.



DEPENDENTS EDUCATIONAL ASSISTANCE: BENEFICIARIES IN TRAINING DURING YEAR 1975-1979

Vocational Rehabilitation

The mission of the vocational rehabilitation program is to assist service disabled veterans to overcome the handicapping effects of their disabilities and to prepare for, obtain, and hold productive employment. Through individualized counseling, each veteran is helped to select a suitable vocational objective and to plan a program of rehabilitation training to achieve the goal selected. The VA provides all necessary medical, prosthetic, and other services (plus special supplies and equipment), and the VA rehabilitation staff maintains close contact with the veteran throughout training to assist as needed. While in training, the veteran receives a monthly subsistence allowance in addition to disability compensation. The costs of tuition, books, supplies, and equipment are paid by VA and upon completion of training, the veteran is helped to secure employment in the appropriate field.

Vocational rehabilitation training was provided to more than 29,000 veterans during FY 1979, three-quarters of whom attended colleges and universities. Trade and technical schools, special training, and on-the-job or farm-related training accounted for the rest.

During FY 1979 special efforts to improve the program focused on carrying out recommendations from the VA "Study of Provisions for Veterans' Vocational Rehabilitation," previously submitted to Congress and the President. The main areas emphasized in the recommendations were 1) need for a broadened scope of services, 2) focus on placement and adjustment in employment as the goal of vocational rehabilitation, 3) more effective service delivery, 4) ongoing training of rehabilitation training staff to ensure the best professional practice, and 5) improved methods of program accountability.

The actions taken to implement study recommendations include submission of proposed legislation embodying the major recommendations of the study and a series of administrative steps to carry out those recommendations not requiring legislative action.

Specific policy determinations and new procedures were issued to expedite scheduling of veterans for counseling, processing of training awards, and procurement of supplies and equipment on a priority basis.

Increased employment assistance is being provided through the VA Career Development Centers (CDC). This program was substantially expanded with the Chief Benefits Director's approval of installation in 33 additional regional offices. CDCs were earlier approved for Atlanta, San Diego, Newark, and Washington, D.C. CDCs are designed to be vital links in expanding personalized career and job assistance service to Vietnam era veterans who are disabled, educationally disadvantaged, or in need of readjustment counseling, and other veterans and beneficiaries in need of such help.

A joint issue by the Department of Veterans Benefits (DVB) and the Department of Medicine and Surgery (DM&S) directs that priority attention be given to the needs of service disabled veterans and establishes improved coordination and integration of the rehabilitation services of both departments. The system provides for ready identification at time of hospital admission of disabled veterans who may need services to improve their employability, and assures that such services are provided on a coordinated basis by DVB and DM&S staff during and following hospitalization. This will involve joint planning and interaction during implementation of the vocational rehabilitation plan that is developed. The responsibility for providing counseling to service-disabled veterans who may be eligible for vocational rehabilitation at VA hospitals has been transferred from DM&S to DVB. Designated staff in each VA medical center and regional office will be assigned rehabilitation case management functions to assure that rehabilitation services are provided in a timely manner during hospitalization.

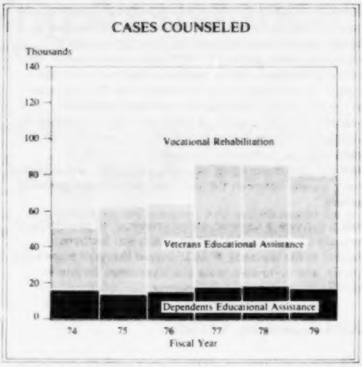
To insure that the practices and methods utilized in the vocational rehabilitation program are in accord with modern concepts and advanced knowledge in the field of rehabilitation, a series of five Central Office directed staff training sessions were conducted. In FY 1979, approximately 475 counseling psychologists and vocational rehabilitation specialists from VA's 57 regional offices (Manila excluded) participated in the training which focused on current techniques of evaluation, counseling, and rehabilitation of seriously disabled veterans. Presentations made by experts in the field of rehabilitation included orthopedic and rehabilitation medicine assessment, psychological and vocational testing, neuropsychological problems of the disabled veteran, rehabilitation engineering, the role of organized labor, and job placement and development strategies.

In addition, a two-day meeting of the Chiefs, Counseling and Rehabilitation Sections and Central Office officials was held. The meeting provided an opportunity for consideration of program operations and administrative matters, as well as technical and professional issues of concern.

Further improvements in the rehabilitation program may be expected as a result of the July 1979 VA Rehabilitation Conference and the recommendations from the follow-up task force later in FY 1980.

Counseling

Educational, vocational, and rehabilitation counseling services are provided under the vocational rehabilitation program, the veterans' educational assistance program, and the survivors' and dependents' educational assistance program. In FY 1979 nearly 120,000 persons were counseled under all programs, an 8 percent decrease from the previous year. This decrease in counseling, the first since 1974, following four consecutive years of growth, was experienced in all programs. The trend in counseling cases over the past seven years is shown in the accompanying chart. Under the vocational rehabilitation program, counseling is required prior to entrance into training; over 39,000 trainees from this program accounted for 33 percent of all counseling cases during FY 1979.



The veterans' educational assistance program accounted for 52 percent of all counseling cases. Counseling is available to eligible veterans and servicepersons upon request and is required prior to reentrance following unsatisfactory progress or conduct. It may be required prior to a second or subsequent change of program. An expected increase in requested counseling materialized in the third quarter of FY 1979 as a result of Public Law 95-202 which reemphasized the Administrator's responsibility for acquainting eligible veterans with the availability and benefits of VA educational and vocational counseling services. Beginning in May 1979 approximately 875,000 brochures containing an application to request counseling were mailed to recently discharged veterans. During the last half of FY 1979 requests for counseling rose by 80 percent over the same period of the previous year and the increase is attributed to the outreach efforts. The mailings continued through November 1979, thus the increase in counseling requests is expected to continue into FY 1980.

Under the survivors' and dependents' educational assistance program, slightly fewer than 18,000 dependents were counseled, decreasing approximately one percent from the previous year, while accounting for 15 percent of all cases seen. Counseling is provided upon request from any eligible dependent (child, spouse, widow, widower), and is required for dependent sons and daughters prior to training unless they have been accepted for, or are pursuing, a college level program at an approved institution. Counseling is also required for all dependents under certain circumstances (unsatisfactory academic progress or conduct, or change of program).

Counseling services were available at nearly 300 locations including 58 VA regional offices, 37 decentralized VA offices, and over 200 contract guidance centers associated with academic institutions and community and private agencies providing appropriate professional counseling and testing services. The number and geographical dispersion of guidance centers and VA counseling offices is intended to make counseling more readily available and accessible to eligible veterans and dependents. Over 60 percent of counseling cases during FY 1979 were completed by VA staff psychologists, the remainder by fee-basis contract centers. In accordance with the policy that VA staff constitute the primary resource for counseling disabled veterans, over 90 percent of those provided counseling for vocational rehabilitation in FY 1979 were seen by VA counseling psychologists. Counseling workloads for veterans' and dependents' education programs were divided nearly equally between VA staff and the contract guidance centers.

During the year a comprehensive review of all psychological tests used in Counseling and Rehabilitation Sections resulted in the issuance of an improved listing of more valid, reliable, and up-to-date tests and inventories for use in counseling veterans and dependents.

State Approving Agencies

State approving agencies were created originally to meet requirements of the World War II programs. Courses offered for training veterans and other eligible persons must be approved by the approving agency of the state where the training facility is located, or by the Administrator. A number of states have designated two or more agencies to carry out this function. The VA negotiated contracts with state approving agencies at a cost to the VA of about $16 million in FY 1979. Services include continuing supervision of schools and training establishments having veterans and other eligible persons enrolled in approved courses.

School Liability

The April 1977 moratorium on processing of school liability cases was lifted in March 1979, and revised consolidated instructions were issued to field facilities for determination of liability and recovery. A school may be held liable for an overpayment to a veteran or eligible person when the payment was a result of false certification or willful or negligent failure of the school to report excessive absences from a course, or discontinuance or interruption. Each station now has a Committee on School Liability for hearings prior to liability determinations. Appeals are forwarded to the Central Office School Liability Appeals Board in the Department of Veterans Benefits.

Housing Assistance

Comparative Highlights

Item	FY 1979	FY 1978	Percent Change
Number of loans			
Guaranteed	364,578	380,869	− 4.3
G I home[1]	357,850	376,561	− 5.0
Mobile home	6,728	4,308	+ 56.2
Direct	1,419	1,830	− 22.5
Average loan amt.			
GI primary home[1]	$44,505	$38,635	+ 15.2
Mobile home	17,339	13,850	+ 25.2
Direct	26,289	25,586	+ 2.8
Maximum interest rate			
G I and direct home	10.5%	9.5%	----------
Mobile home	12.0%	12.0%	----------
G I loans outstanding[2]	4,040,006	4,002,406	+ 0.9
In default	48,141	49,448	− 2.6
Defaults as % of total	1.19	1.24	----------
Number of loans			
Using restored entitlement	38,941	37,872	+ 2.8
Condominium	3,482	3,320	+ 4.9
Refinancing	9,752	12,459	− 21.7
Substitutions of entitlement	6,925	4,698	+ 47.4
Specially adapted housing grants	724	609	+ 18.9
Properties on hand	9,453	11,291	− 16.3

1 Includes condominiums

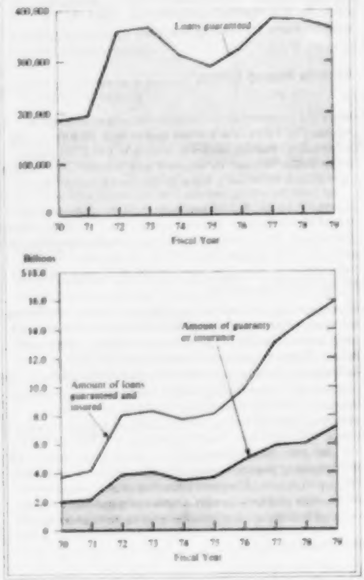
2 End of fiscal year

Summary

During the seventies, VA home loan activity increased substantially over the prior decade. The number of home loans guaranteed per year during the sixties averaged 177,117, while during the seventies the number rose to 321,862. The average VA guaranteed loan rose from $18,970, at the end of the sixties, to $48,960, ten years later.

Legislative changes beginning in 1970 contributed to the increased activity in the VA housing program during the

VA GUARANTEED AND INSURED LOANS
1970-1979



seventies, including FY 1979. Among these legislative changes, the Veterans' Housing Act of 1970 authorized mobile home, refinancing, and condominium loans, and with the Veterans' Housing Act of 1974, more condominium projects became potentially eligible for VA approval. Also under the 1974 Act, veterans who previously obtained a loan may regain entitlement if the property is disposed of and the loan paid in full, or if another eligible veteran assumes the balance of the VA loan and substitutes his or her own entitlement. The same legislation allows non-supervised lenders who meet standards prescribed by VA to make guaranteed loans without prior VA approval.

During FY 1979, the final fiscal year of the decade, nearly 374,000 veterans were assisted with home ownership under the VA housing program. VA guaranteed loans totaled over $16 billion, direct loans amounted to $37 million, and grants for specially adapted housing totaled $20 million. The number of mobile home and condominium loans increased during the fiscal year, as did substitutions and restorations of entitlement. This high level of activity was maintained in spite of disrupted money markets and the highest mortgage interest rates in history. A program milestone was reached during the year when the 10 millionth home loan was guaranteed.

Mobile Home Loans[1]

Since the inception of the mobile home loan program in February of 1971, the VA has guaranteed 33,684 mobile home loans, thereby assisting lenders in providing nearly $396 million in loans to veterans who probably would have been unable to afford a home in the conventional market.

During FY 1979, 8,204 applications were received and 6,728 mobile home loans amounting to $117 million were guaranteed. The number of loans guaranteed represents an increase of 56 percent from FY 1978, and over one-half were made by non-supervised lenders that were approved for automatic processing.

Of the loans guaranteed during the fiscal year, 6,342 were for the purchase of new mobile homes while 386 were for used units. Over 63 percent of loans were for single-wide mobile homes in an average amount of $15,164; the average for double-wides was $21,069. These amounts are considerably higher than previous years partly because the Veterans' Housing Benefits Act of 1978 removed the statutory loan maximums of $12,500 for a single-wide home, $20,000 for a double-wide, and $7,500 for a lot. The Act also changed the guaranty to the lender from a flat 50 percent of the loan amount to 50 percent or $17,500, whichever is less. The maximum maturity for loans on single-wide mobile home units was increased from 12 years, 32 days to 15 years, 32 days by the same law.

Plant Inspections

Each plant producing mobile home units to be sold to veterans is inspected quarterly to see that the units produced and the manufacturing processes are in compliance with Federal Mobile Home Construction and Safety Standards.

The inspection of the manufacturing process involves observing the handling of materials and the assembly operation at all stages of construction. In addition, the quality control program is checked, including the type of materials used and the provisions for protecting materials during storage.

A total of 416 mobile home plant inspections were made by VA during FY 1979, and an additional 945 inspections by third party inspectors were accepted as meeting VA requirements. No evidence of non-compliance with Federal standards was noted. The inspection requirements in the National Mobile Home Construction and Safety Standards Act of 1974, as implemented by the Department of Housing and Urban Development, appear to have improved quality control of manufacturers, leading to a substantial reduction in deficiencies in the mobile home manufacturing processes.

Experience with the mobile home industry as well as local, state, and area associations has been good. VA has received full cooperation of all parties concerned with VA inspections. There have been no reported instances of flagrant, willful violations of construction standards, and no instances of manufacturers' refusing to cooperate or permit inspection.

Mobile Home Onsite Inspections

During FY 1979, 1,152 mobile homes secured by guaranteed loans were randomly selected for inspection. Each inspection covered the home and its site and included where possible, an interview with the veteran owner or spouse, or both.

In some cases the inspectors were unable to check some of the items and, therefore, total responses relating to a particular item do not always equal the total number of inspections. The percentage figures given below relate to the total number of responses for a particular item.

The inspectors found that 75 percent of the mobile homes were located in mobile home parks and 25 percent were on individual sites, which are the same percentages reported for the previous year.

They found that 94 percent of the units were at the locations named in the original loan applications and that 6 percent had been moved from the locations specified in the applications, as opposed to 81 percent and 19 percent, respectively, during the previous year.

The average size of the units inspected was 1,047 square feet, an increase of 98 square feet during the year. With only one exception, the inspectors considered the size of the lot to be adequate for the mobile home. Automobile parking was available for 97 percent of the mobile homes. Community or public water facilities were connected to 69 percent of the homes, while 31 percent had private water supply systems. Sewage was disposed of through public or community disposal systems in 61 percent of the homes and the remaining 39 percent were equipped with individual septic tank systems. At the time of the inspections, 73 percent of the units had skirting and 71 percent had tiedowns adequate to withstand hurricane-force winds. Forty-four percent of the homes were reported in excellent general condition and 56 percent in good condition.

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[1] *This information is included in compliance with Section 1819, Title, 38, U.S.C.*

Interviews were conducted with occupants of 77 percent of the units inspected. Their units had been occupied on an average of about 6 months at the time of the interviews. The average interview lasted 25 minutes, and some of the results follow:

- 100 percent were satisfied with the treatment received from VA;
- 98 percent were satisfied with their lenders;
- 97 percent of those located in a mobile home park were satisfied with their park operators;
- 74 percent were satisfied with their dealers.

As to future housing plans, 60 percent planned to remain in their mobile homes at the current site, 19 percent wanted to move into conventional housing, and 21 percent wanted to move their homes to other sites.

Compliance With Warranty

Every new mobile home financed by a GI loan must have a written warranty from the manufacturer to the purchaser, which includes a specific statement that the mobile home meets the standards prescribed by the VA.

During FY 1979, VA field stations reported 158 complaints from veterans expressing some dissatisfaction with their mobile home units; 152 of these complaints were considered justified. By the end of the fiscal year, 102 of the justified complaints had been resolved and 50 were pending resolution. Of these complaints, 123 were under warranty, 8 were due to faulty setup, and 21 were attributed to both warranty and faulty setup.

The nature of the complaints covered under warranty varied from minor to severely defective items to be repaired. A total of 109 justified complaints were reported because of flawed construction of the unit; 42 dealt with both construction and furnishings; and 1 expressed dissatisfaction with only the furniture and appliances.

The VA continues to act promptly to determine the validity of the complaints received. Complaints are widely distributed among manufacturers and models, with no single manufacturer accounting for a significant percentage of the total complaints.

Profile of Mobile Home Market vs. GI Home Market

The primary beneficiaries of the VA mobile home program are, for the most part, the younger, lower income veterans and servicepersons who cannot afford conventional housing.

Although the number of mobile home loans guaranteed represents only a small percentage of the total loans guaranteed, it is evident that veterans obtaining mobile home loans are those for whom the program is intended. The table below compares selected characteristics of mobile home loans to those of GI loans on conventional homes. Income, housing expense, and asset figures shown are based only on loans which were submitted for VA approval prior to loan disbursement. Condominium loans are not included with home loans.

Characteristics	Mobile Home Loans	Home Loans
Average maturity (months)	179	357
Average purchase price	$18,118	$46,452
Average loan amount	$17,340	$44,411
Average gross monthly income	$ 1,310	$ 1,767
Average net monthly income	$ 885	$ 1,204
Average monthly housing expense	$ 342	$ 546
Average assets	$ 1,596	$ 5,724
Housing expense as a percent of gross monthly income	26.1	30.9
Housing expense as a percent of net monthly income	38.6	45.3

Mobile home buyers were somewhat younger than other GI loan recipients. Thirty percent were 27 years old or less, compared to only 17 percent of conventional home purchasers. Fifty-seven percent of them were Vietnam era veterans.

Defaults

When the VA mobile home loan program was established, it was anticipated that the incidence of defaults and claims would be greater than that experienced for loans on conventional homes. During FY 1979, claims paid as a percent of the average number of outstanding mobile home loans, dropped to 3.4 percent from 3.7 percent during FY 1978. The rate for guaranteed loans on conventional homes was 0.3 percent during FY 1979.

Direct Loans

The purpose of the direct loan program is to give all veterans an equal opportunity to purchase homes even though they live in areas where private lenders are not interested in the loan guaranty program or have insufficient funds to make such mortgages. VA is authorized to designate such rural areas, small cities and towns as "housing credit shortage areas". The veteran applies directly to the VA for these loans which can be used for the purchase, construction, repair, and alteration of homes and farm houses. Direct loan terms are the same as those in effect for guaranteed loans, and the maximum loan amount is $33,000.

To date, the VA has made 331,837 direct loans in an aggregate amount of $3.4 billion. Because of the general availability of private funds for guaranteed loans, only 1,419 direct loans were made in FY 1979. While the number of loans dropped 22 percent from FY 1978, the average amount increased 3 percent to $26,298.

GI Home Loans

The GI home loans guaranteed during FY 1979 include refinancing, condominium, and alteration and repair loans. The total also includes direct loans sold and guaranteed, in addition to loans for the purchase of the traditional single-family home.

Almost 69 percent of the veterans purchasing a home with guaranteed loans were able to obtain them with no downpayment. Loans averaging $43,114 to finance the purchase of previously occupied housing accounted for 79 percent of the primary home loans guaranteed during the fiscal year. The average price of previously occupied homes was $44,842. On newly constructed homes, the average loan was $49,701 and the average purchase price was $52,880.

Nearly 71 percent of home loans guaranteed during FY 1979 went to Vietnam and post-Vietnam era veterans and servicemen, 11 percent to veterans whose entitlement was restored, 10 percent to post-Korean veterans, 5 percent to World War II veterans and 3 percent to Korean veterans. Veterans whose period of service was between World War II and Korea have been eligible for loan benefits since October 1, 1976, but accounted for only 0.2 percent of the total volume in FY 1979. Unmarried surviving spouses also accounted for 0.2 percent, and 10 loans were guaranteed for spouses of service personnel classified as prisoners of war or missing in action.

Between June 22, 1944 and September 30, 1979, veterans obtained over 10.3 million home loans totaling over $170 billion under the GI home loan program.

Credit Market Developments

During FY 1979, the VA home loan program operated under restrictive credit market conditions when both short-term and long-term interest rates reached the highest level in the nation's history, topping interest rates paid during the Civil War. For example, the Federal Reserve increased its discount rate three times during the year, from 8 to 11 percent. In response to the rise in market interest rates, VA was forced to increase the maximum contract rate on VA guaranteed home loans twice during the year, from 9.5 to 10.5 percent.

The housing sector is unusually vulnerable to tight money and high interest rates, which most often result in a decline in demand for housing loans. In addition, some major suppliers of mortgage funds, e.g., mutual savings banks and savings and loan associations, are highly sensitive to tightening monetary conditions. During FY 1979, the impact on the mortgage market of a shortage of deposits in savings institutions was substantial, causing mortgage funds to become scarce and interest rates to increase to record high levels.

The VA interest rate ceiling is one of the most important factors governing whether the VA home loan program can effectively serve the credit needs of veterans. During the fiscal year, VA made every effort to keep the interest rate ceiling competitive to assure lender support of the program.

Funding Operations

No appropriations are required to pay claims and fund property management operations. Both the guaranteed loan and direct loan programs are financed from revolving funds derived from principal and interest payments made to VA and proceeds of VA loan sales.

During FY 1979 VA collected $317.8 million in principal and interest payments, with the interest portion amounting to $108 million.

Specially Adapted Housing Assistance

The lack of mobility and the psychological problems associated with paraplegia often impose tremendous burdens on its victims. Simple tasks become difficult and complex activities and some procedures, such as acquiring a suitable home, are almost impossible without assistance.

Severely disabled veterans have distinctive housing needs such as wide doorways to accommodate wheelchairs, ramps instead of steps, oversized and specially equipped bathrooms, etc. VA extends whatever help is required to those declared eligible for grants for specially adapted housing. Assuring that structural requirements are met is only one aspect of the specially adapted housing program. Frequently VA representatives escort the veteran or take his place during contacts with builders, lenders, and architects.

Because of the difficulty such veterans experience in obtaining loans from private lenders on some occasions, the VA is authorized to make direct loans for specially adapted housing without regard to geographic location. Since this authorization was granted in the Veterans Housing Act of 1970, direct loans have been made to 301 disabled veterans for a total of $6.2 million.

During FY 1979, 724 severely disabled veterans received grants totaling $20 million to buy, build or modify homes specially adapted for their use. Since 1948, when these grants were first authorized, 16,612 veterans have been aided by grants amounting to over $229 million.

Fair Housing Program

Minority participation in the guaranteed home loan program continued at a high level during FY 1979. Minorities comprise 11 percent of the veteran population and obtained 16 percent of the home loans closed in FY 1979. Black veterans obtained 11 percent, Hispanic veterans 4 percent, Asian/Pacific Island veterans 0.9 percent and American Indian/Alaskan Native veterans 0.5 percent of the total loans.

Spouses' income continued to be important in the approval of VA guaranteed loans, reflecting rapidly increasing home prices, interest rates, and other homeowner expenses. During FY 1979, 43 percent of all VA guaranteed loans closed would not have been approved without the supplemental income of the applicant's spouse; the previous year's figure was 39 percent. The second income was even more important for minority home buyers; 53 percent of black, 49 percent of Hispanic, 43 percent of American Indian/Alaskan Native, and 58 percent of Asian/Pacific Islander veterans who obtained VA guaranteed loans relied upon spouses' income.

No downpayment was made by 84 percent of the black, 74 percent of the Hispanic, 78 percent of the American Indian/Alaskan Native, 71 percent of the white, and 56 percent of the Asian/Pacific Islander veteran home buyers.

During FY 1979, the average purchase price of homes for all veterans was almost $46,500. It was approximately $62,300 for Asian/Pacific Islander, $47,000 for white, $46,400 for American Indian/Alaskan Native, $44,800 for Hispanic and $40,100 for black guaranteed home loan participants.

The Asian/Pacific Islander, white and American Indian/Alaskan Native veterans who on the average purchased higher priced homes, also had higher average incomes than black and Hispanic home buyers. The ratio of housing expense to income ranged from 32 percent for blacks, to 38 percent for Asian/Pacific Islanders purchasing homes with VA guaranteed loans.

The VA maintains a home counseling service in 23 cities to provide potential home buying veterans advice and assistance in practical aspects of home buying and homeownership. Over 6,900 minority veterans availed themselves of this service during FY 1979.

Minority businesses received over $11 million or 13 percent of all commissions and fees paid and assignments made by VA during FY 1979 for work related to the guaranteed loan program. This included minority sales brokers, fee appraisers, compliance inspectors, repair and maintenance contractors, and management brokers.

Life Insurance

Comparative Highlights

Program (in thousands)	FY 1979	FY 1978	Percent Change
USGLI			
Policies	**108**	116	− 6.9
Amount	**$441,620**	$479,787	− 8.0
Death benefits	**$34,555**	$36,032	− 4.1
NSLI[1]			
Policies	**3,669**	3,750	− 2.2
Amount	**$25,069,543**	$25,506,038	− 1.7
Death benefits	**$313,770**	$307,699	+ 2.0
VSLI[1]			
Policies	**547**	570	− 4.0
Amount	**$4,792,286**	$4,986,431	− 3.9
Death benefits	**$18,067**	$16,928	+ 6.7
SDVI			
Policies	**186**	182	+ 2.2
Amount	**$1,684,684**	$1,642,902	+ 2.5
Death benefits	**$16,683**	$16,810	− 0.8
VRI			
Policies	**171**	174	− 1.7
Amount	**$1,184,486**	$1,208,399	− 2.0
Death benefits	**$12,941**	$12,509	+ 3.5
SGLI			
Policies	**3,142**	3,193	− 1.6
Amount	**$62,606,808**	$63,390,355	− 1.2
Death benefits	**$94,767**	$96,881	− 2.2
VGLI			
Policies	**487**	422	+15.4
Amount	**$9,528,386**	$8,182,886	+16.4
Death benefits	**$25,666**	$21,663	+18.5
VMLI			
Policies	**6**	6	0.0
Amount	**$142,261**	$129,796	+ 9.6
Death benefits	**$3,702**	$2,796	+32.4

[1] *Includes paid-up additional insurance purchased by dividends.*

Summary

Life insurance protection for the nation's service personnel and veterans is provided under five separate programs administered by the VA and three programs supervised by the VA.

Program	Abbreviated Reference	Policy Prefix Letter	Program Beginning	Ending Date of New Issues
U.S. Government Life Insurance	(USGLI)	K	01-01-19	04-24-51
National Service Life Insurance	(NSLI)	V H	10-08-40 08-01-46	04-24-51 12-31-49
Veterans Special Life Insurance	(VSLI)	RS, W	04-25-51	12-31-56
Service Disabled Veterans Insurance	(SDVI)	RH	04-25-51	Open
Veterans Reopened Insurance	(VRI)	J, JR, JS	05-01-65	05-02-66
Servicemen's Group Life Insurance	(SGLI)	—	09-29-65	Open
Veterans Mortgage Life Insurance	(VMLI)	—	08-11-71	Open
Veterans Group Life Insurance	(VGLI)	—	08-01-74	Open

The first five programs shown in the accompanying table are entirely VA administered and the latter three are supervised through a contractual relationship with private companies. The SGLI and VGLI programs are administered by the Prudential Insurance Company of America, Newark, New Jersey and the VMLI program by the Bankers Life Insurance Company of Lincoln, Nebraska.

At the end of FY 1979 these eight programs provided coverage exceeding $105 billion to nearly 8 million insureds.

Government Administered Programs

United States Government Life Insurance (USGLI)

This is the oldest government administered insurance program, established in 1919 to handle the conversion of World War I Risk Term Insurance. At the end of FY 1979, 108,000 of these policies remained in force, a decline of 8,000 from the previous year. The program is self-supporting except for administrative expense and claims traceable to the extra hazards of military service, which are paid by the government. There has been a steady decline in the number of policyholders which will continue to accelerate as the average age of these insureds is now over 76 years. Dividends are paid to USGLI policyholders from excess earnings of the Trust Fund. The 1979 dividend payments will average $256 per insured, compared to $224 in 1978.

National Service Life Insurance (NSLI)

This program was established October 8, 1940 to serve the insurance needs of World War II service personnel. By the end of FY 1979, nearly 4 million of these policies remained in force with a face value of $25 billion. The program is also self-supporting except for administrative expense and claims traceable to the extra hazards of military service, which are paid by the government. The 1979 dividend payments from the excess earnings of the Trust Fund averaged nearly $128 per insured compared to $117 last year.

Approximately 34 percent of the NSLI policies are term insurance renewed every five years at the current attained age; premiums increase with each renewal. As the policyholders grow older, the premiums can become prohibitive, causing many to reduce the face amount of their policies. The VA makes continuous efforts to alert term policyholders about the high premium rates if they retain these policies to the older ages and encourages them to convert to a permanent plan of insurance.

Legislation establishing the Modified Life Age 65 and Age 70 plans of insurance has been beneficial to the term policyholders as the premium rates are lower than for any previous plans in existence. As of September 30, 1979 there were nearly 450,000 Modified Life policies in force with a face value of over $3 billion.

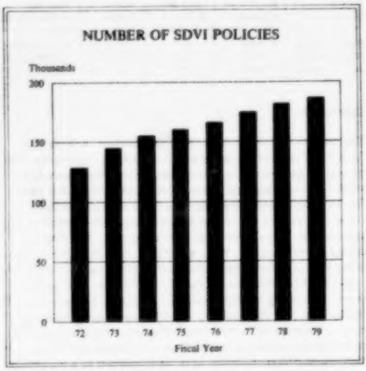
NSLI policyholders may use dividends to buy more insurance as paid-up additions to their policy, permitting policyholders to have more than $10,000 government life insurance in force. A total of 840,000 policies have paid-up additions with a face value over $1 billion, an increase of 17 percent over 1978.

Veterans Special Life Insurance (VSLI)

This insurance program was made available within 120 days following separation to veterans separated from service on or after April 25, 1951 through December 31, 1956. VSLI was a means of providing post-service government life insurance for Korean conflict veterans for whom there was no premium paying insurance during service. The government provided insurance protection with a $10,000 Servicemen's Indemnity. During the above stated period about 800,000 policies were issued of which 547,000 remained in force on September 30, 1979 with a face value of nearly $5 billion. Initially, only renewable term insurance was available. Effective January 1, 1959, legislation modified this program to permit exchange to a lower cost term policy which was nonrenewable after age 50, or to convert to a permanent plan of insurance. This program was originally nonparticipating (no dividends payable), but Public Law 93-289, effective May 24, 1974, changed this insurance to participating. The 1979 dividend payments will amount to $26 million, an average of $48 per insured compared to $29 in 1978. A total of 103,000 policies have paid-up additions with a face value of close to $30 million.

Service Disabled Veterans Insurance (SDVI)

The only government administered insurance program remaining open to new issues, SDVI was designed to assure that service disabled veterans could obtain life insurance at standard rates. Every veteran separated from service on or after April 25, 1951, who receives a service connected disability rating for which compensation would be payable if 10 percent or more in degree, and who is otherwise insurable, has one year from the date of notice of the VA rating to apply for this coverage. The VA makes a special effort to assure that all eligible veterans are made aware of this coverage, by issuing a notice of eligibility at the time a VA service connected rating is granted; a reminder notice is sent about six months later. In addition, the program is publicized through veterans' organizations and periodic information releases to the press, and radio and television stations. Since the program insures substandard risks at standard premium rates, it is not self-supporting and requires periodic appropriations to meet the costs. At the end of FY 1979 there were 186,000 policies in force with a face value close to $1.7 billion.


NUMBER OF SDVI POLICIES

Veterans Reopened Insurance (VRI)

This program was a limited reopening of National Service Life Insurance for certain disabled World War II and Korean conflict veterans who because of their disability, would be unable to obtain commercial life insurance or could not obtain it at a reasonable cost. Applications for this insurance were accepted from May 1, 1965 through May 2, 1966.

About 210,000 policies were issued of which 171,000 remained in force at the end of FY 1979 with a face value over $1 billion. The Administrator may adjust premium rates up or down at intervals of not less than two years to keep the program self-supporting.

Total Disability Income Provision (TDIP)

This is an optional rider that an insured may add to the basic policy to provide a monthly income in case of disability. By paying an extra premium and meeting the age and good health requirements, this rider may be added to any government administered policy except SDVI.

TDIP provides a monthly benefit of $5.75 per $1,000 of USGLI insurance for total disability, and as of September 30, 1979, over 2,500 riders were in force with a face value of $20 million. TDIP riders have been issued on NSLI policies under three different versions of the law. Under the original provisions, these riders paid $5 per $1,000 of insurance with coverage to age 60. Subsequent changes first increased the payment to $10 per $1,000 to age 60 and later extended the coverage to age 65. The accompanying table shows the modifications to the law affecting NSLI policies and the current status of these three different riders.

Effective Date of Modification	Monthly Income per $1,000 of Insurance	Coverage to Age	In Force as of Sept. 30, 1979	
			No. of Policies	Amount of Insurance (in Thousands)
Aug. 1, 1946	$ 5.00	60	10,221	$ 75,400
Nov. 1, 1958	10.00	60	115,632	836,850
Jan. 1, 1965	10.00	65	449,128	3,583,165

Civil Relief

The VA administers Article IV of the Soldiers' and Sailors' Civil Relief Act which deals specifically with commercial life insurance purchased by service personnel. This insurance must be purchased and in force on a premium paying basis for 180 days before the insured enters onto active duty. In order that service personnel may continue the protection provided by their commercial insurance policies during a period when they may have a reduced income, the Act provides that premiums becoming due and not paid by the insured shall be treated as a loan by the insurer. The government guarantees to the insurer the repayment of any indebtedness not liquidated by the insured, making such payment a debt owed to the United States by the insured. The terms of the Act exclude any form of government life insurance and limit the amount to be protected to a maximum of $10,000. This program is nearing extinction. On September 30, 1979, 15 policies were protected under this Act compared to 17 as of September 30, 1978.

Government Supervised Programs

Servicemen's Group Life Insurance (SGLI)

This program, which provides insurance coverage for members of the uniformed services, is supervised by the VA, but administered by the Prudential Insurance Company of America as primary insurer through the Office of Servicemen's Group Life Insurance, Newark, New Jersey. During FY 1979, 431 other commercial companies also participated in the SGLI program on a reinsurer/converter or converter only basis. By the end of FY 1979, over 3 million active duty service personnel and reservists were insured in the amount of $63 billion, and death benefits paid during the year amounted to $95 million compared to $97 million for FY 1978.

The maximum coverage is $20,000 and the serviceperson is automatically insured for this amount in the absence of a written request for less ($15,000; $10,000; or $5,000) or no coverage. Full-time or part-time SGLI coverage has also been extended to certain members of the Reserves, National Guard, and ROTC. Members in the four service academies (U.S. Military Academy, U.S. Naval Academy, U.S. Air Force Academy, and U.S. Coast Guard Academy) are entitled to full-time coverage.

Veterans Group Life Insurance (VGLI)

This program, which provides for the conversion of SGLI to a 5-year nonrenewable term policy, was designed to provide low cost government supervised insurance to the veteran immediately following separation or release from service. A large percentage of Vietnam era veterans failed to exercise their right to convert SGLI to a permanent plan of insurance possibly due to limited income immediately after service, completion of schooling, or lack of family responsibility.

This group coverage was effective August 1, 1974 and is available in amounts of $20,000, $15,000, $10,000 or $5,000 but for not more than the amount of SGLI which was in force at the time of separation. VGLI has no cash, loan, paid-up or extended insurance values, but can be converted to a permanent policy with one of the participating companies at the end of the five-year term period. As of September 30, 1979, 487,000 veterans were insured for nearly $10 billion.

Shortly following release from duty, the VA mails to all eligible veterans an informational pamphlet and an application for VGLI.

This program is also available to reservists who, while performing active or inactive duty for training under a call or order specifying a period of less than 31 days, suffer an injury or disability which renders them uninsurable at standard premium rates.

Veterans Mortgage Life Insurance (VMLI)

This program is supervised by the VA, administered by the Bankers Life Insurance Company of Lincoln, Nebraska and provides mortgage protection life insurance to a maximum of $40,000 for any veteran who receives a VA grant for specially adapted housing, unless he or she declines, fails to furnish information to establish the premium, or does not pay the premium. Any unused portion is transferable to a subsequent home mortgage after the preceding one is disposed of, and coverage ceases when the mortgage is paid off, the home is sold, or the veteran reaches age 70.

The monthly premium paid by the disabled veteran is the same as that charged for standard lives, with the government paying the extra mortality costs and administrative expenses. The premiums collected under this program are not sufficient to pay claims and the deficit is made up by transfers from the Compensation and Pension appropriation.

As of September 30, 1979, there were over 5,800 VMLI policyholders; death benefits paid during the fiscal year totaled close to $4 million.

Veterans Assistance

Comparative Highlights

	FY 1979	FY 1978	Percent Change
Public telephone calls - toll-free	**4,782,046**	4,170,420	+ 14.7
Public telephone calls - other	**10,378,831**	12,298,049	- 15.6
Interviews away from office	**157,327**	220,028	- 28.5
Interviews at office	**2,974,738**	3,623,934	- 17.9
Patient interviews	**481,888**	462,126	+ 4.3
Correspondence	**2,768,677**	2,779,849	- 0.4

Summary

Veterans Assistance personnel in Veterans Services Divisions in field stations conducted over 15 million telephone interviews during FY 1979. The toll-free telephone service continued to increase with over 600,000 more calls than the preceding year. Correspondence continued at about the same level, declining less than one percent. The decline in other actions results largely from fewer persons in education and training programs and reductions in Vet Rep staffing.

Compliance surveys of establishments approved for the education or training of veterans totaled 11,800, a small decrease from FY 1978.

Outreach

As directed by Title 38, U.S.C., the Veterans Administration conducts an outreach program to inform veterans of the benefits and services to which they may be entitled. This outreach program places a high priority on reaching certain categories of veterans, including the educationally disadvantaged, minority groups, the disabled, the unemployed, the aging and the incarcerated.

Telephone contact is fundamental to this effort. Since completion of the toll-free telephone network in all 50 states the use of these lines has shown a steady increase even when other actions declined. The 950 local, Foreign Exchange (FX) and Wide Area Telephone Service (WATS) lines provide a fast, easy, and inexpensive means of contacting VA for information and assistance in connection with veterans' benefits in general or in specific cases. Enterprise Toll-Free Service is provided in two states (Hawaii and Rhode Island) and Zenith Toll-Free Service is provided in Alaska. Availability of this service is widely publicized. The numbers appear in telephone directories, and newspapers, radio, and TV are used to announce toll-free service. Posters are displayed in appropriate locations and enclosures are inserted in outgoing mail. Many members of Congress have assisted in publicizing the service, and its existence is highlighted in VA pamphlets.

VA is participating in the White House Veterans Federal Coordinating Committee in establishing Veterans Outreach and Community Services (VOCS) programs in 11 cities selected for initial implementation of pilot programs.

The VA, with safeguards to assure proper use, also provides lists of names and addresses of veterans to local governments wishing to notify them of benefits being made available to veterans by local governments.

Mobile Vans

During FY 1979 it was determined that better service could be provided to handicapped veterans by allowing VA hospitals to use mobile office vans to transport wheelchair patients home for holidays and to events outside the facility. As a result, all vans were transferred to VA hospitals in May 1979. Prior to the transfer the vans had been in operation within the Veterans' Services Division, and during 1979 they visited 31 communities, traveled 7,900 miles, and interviewed nearly 1,500 veterans, about 9 percent of whom were Vietnam veterans interviewed for the first time.

Incarcerated Veterans

Nowhere are adjustment problems for Vietnam era veterans more obvious than among those who are incarcerated. Service to incarcerated veterans began soon after World War II, receiving new emphasis since April 1975. Since then, almost 8,000 scheduled visits have been made to 371 Federal and State prisons in all 50 states; almost 38,000 incarcerated veterans have been provided information on VA benefits in group sessions; and more than 82,000 incarcerated veterans have been counseled individually. In addition, almost 3,800 briefings for 8,300 prison officials have been held to acquaint prison staffs with the benefits and services available to inmates.

The Presidential Review Memorandum of October 1978 charged the Law Enforcement Assistance Administration (LEAA) and the Bureau of Prisons with the responsibility for developing reliable statistics regarding the numbers and characteristics of Vietnam era veterans in prisons and jails. In response to this Presidential Review Memorandum the Veterans Administration, LEAA, and Bureau of Prisons have jointly launched a massive information dissemination program aimed at informing personnel and inmates in the entire criminal justice system about veterans' benefits and services and how they can be used effectively to help in the prisoners' rehabilitation programs. As a part of this effort, the VA has published a new informational pamphlet entitled "Veterans Benefits - Inside . . . Outside" designed specifically for incarcerated veterans and those on probation or parole. This pamphlet, and other material concerning veterans' benefits, was sent to approximately 375 prisoner-assistance organizations, 3,200 jail administrators and 26 staff agency consultants for institutional library services. In addition, most regional offices conducted familiarization workshops to brief officers about veterans' benefits and services available to incarcerated veterans. Starting in July 1979, 108 such workshops were conducted by Veterans Benefits Counselors and other regional office representatives for more than 1,300 correctional system officials. Approximately 80 personnel representing the Department of Medicine and Surgery (DM&S) participated in these workshops.

Recommendations for Improvement of Outreach During FY 1980[7]

The Veterans Outreach Services Program as specified in Title 38, U.S.C. charges VA with seeking out veterans and dependents and providing them with the services described. The categories of veterans identified as most in need of outreach services are the disabled, the educationally disadvantaged, the incarcerated, and the elderly. However, because the program is related to educational benefits and was inaugurated to deal with an emergency, it has been reduced every year by budget cuts and thereby the effectiveness of the outreach program has been impaired. VA is proposing legislation to provide for outstationing VA employees in locations remote from VA Regional Offices where they can, with minimal travel expenditures, provide service and assistance to veterans and dependents in the area. With this legislative change and with the needed funds provided in appropriation channels, VA proposes an intensive program to reach the categories of veterans in need of outreach to provide them with the information and assistance needed to obtain maximum benefits.

U.S. Veterans Assistance Centers

These centers called USVACs were originally established with the idea of providing one-stop locations where veterans could obtain information about and assistance in applying for various Federal benefits. At present the centers are located with VA Regional Offices or subsidiary VA offices, and in some cases a Veterans' Employment Representative is present full- or part-time. For the most part a USVAC is composed of a single experienced VA employee to whom all incoming veterans making a first visit are referred. This employee discusses all available benefits and provides assistance in applying for those in which the veteran displays an interest. The employee also follows up with those veterans who are identified from their service record as being educationally disadvantaged (14,000 in FY 1979). Follow-ups are made by phone and, where that is not possible, by correspondence. Every effort is made to get such veterans to visit or otherwise communicate with the VA installations.

Employment Assistance

The VA works with the Department of Labor (DOL) to provide job and job training service to veterans. The VA cooperates in the Disabled Veterans Outreach Program and the Comprehensive Employment and Training Act program by providing names and addresses and by providing veterans' benefits training. VA also provides lists of names and addresses of on-the-job training employers to be used by State Employment Security Administrations (SESAs) in developing job opportunities. Also, Veterans' Employment Representatives are stationed in some U.S. Veterans' Assistance Centers. VA also participates in the Help through Industry Retraining and Employment (HIRE II) program. In FY 1979, 57,727 veterans requested that VA provide employment assistance and through various referrals 14,336 obtained employment. Of this total 876 obtained employment through the Office of Personnel Management, 9,401 obtained employment through SESAs, 2,337 obtained employment through VA contacts, and 1,722 were placed through other contacts.

Veterans Education and Training Representatives

Reduction in this staff continued throughout the year; at the end of FY 1979 there were fewer than 300 Vet Reps compared to the original staff of 1,327, and 880 at the end of FY 1978. During the year they conducted nearly 862,000 interviews; completed 750,000 certifications needed for payment purposes; conducted 2,800 field examinations, 400 compliance surveys, and 1,300 liaison visits. They also assisted in resolving many inquiries dealing with educational assistance payments.

Fiduciary and Field Examination Activity

The Fiduciary and Field Examination Activity of Veterans Services Division supervised the payment of benefits to fiduciaries on behalf of nearly 116,000 adult beneficiaries who were incompetent or under some other legal disability during FY 1979. In addition, the activity supervised the payment of benefits to 27,500 minor beneficiaries. This supervision translated into 88,864 fiduciary program field examinations, 49,219 fiduciary account audits, 21,850 legal actions prepared, 5,068 court appearances, and 4,745,716 miles traveled. The F&FE Activity was also responsible for performing 14,589 non-fiduciary program field examinations, and 906 special investigations.

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[7] *This information is included in compliance with section 245, Title 38, U.S.C.*

It is projected that the rise in the average age of the veteran population will cause the number of adults under supervision to grow.

Equal Opportunity Compliance

VA field station personnel conducted an equal opportunity compliance program to ensure that education and training offered to veterans and other eligible beneficiaries were provided without discrimination on the grounds of race, color, national origin, or sex in enforcement of Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972. As of September 1979 there were 231 field station employees assigned to share the equal opportunity compliance responsibility along with their educational compliance functions and an additional 17 personnel detailed from other responsibilities to assist in conducting compliance reviews and investigating complaints of discrimination. They conducted 5,611 onsite equal opportunity reviews in FY 1979 in proprietary schools below college level, apprenticeship programs, and job training establishments. This represents a decrease of about 18.6 percent from FY 1978. They also conducted nine investigations of complaints of discrimination, of which one was found valid. Six other complaints against institutions of higher learning were referred to the Department of Health, Education, and Welfare, which under a joint agreement has jurisdiction over such schools.

National Cemetery System

Comparative Highlights

Item	FY 1979	FY 1978	Percent Change
Interments in national cemeteries	39,248	36,744	+6.8
Applications for headstones/markers	254,833	255,324	−0.2
Headstones/markers ordered	230,600	225,435	+2.3

Summary

The Department of Memorial Affairs (DMA) is responsible for the National Cemetery program, the Headstone and Marker program, the Memorial Marker and Plot program, and the State Cemetery Grants Program.

In FY 1979, DMA accomplished over 39,000 interments and ordered 230,600 headstones and markers for the unmarked gravesites of eligible persons. The Office of Director, State Cemetery Grants, was staffed to begin formulation of procedures and regulations for the State Cemetery Grants Program, which was established as part of the Veterans' Housing Benefits Act of 1978 (Public Law 95-476).

Several significant events took place in FY 1979 in keeping with the VA's responsibility to provide special ceremonies to honor our nation's veterans. These special occasions included:

(1) The opening of the Riverside, California, National Cemetery on November 11, 1978, where the Deputy Administrator unveiled the dedicatory plaque.

(2) Ceremonies at Arlington National Cemetery on Veterans Day, November 11, 1978, where President Carter and Administrator Cleland unveiled the dedicatory plaque honoring Vietnam veterans.

(3) Ceremonies at each national cemetery during Memorial Day weekend, beginning May 26, 1979. This period also marked the beginning of Vietnam Veterans Week. At the Tomb of the Unknown Soldier in Arlington National Cemetery, the Administrator dedicated a wreath honoring Vietnam veterans.

(4) On July 18, 1979, services in honor of MIA-POW Recognition Day were held at the National Cathedral in Washington.

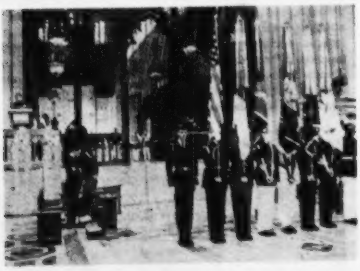
In its first full year as a Department, significant achievements were made in many areas. DMA developed a consumer complaint handling system, studied its manpower program, and developed revised output indicators for further consideration. Policies on graveside committal services in national cemeteries are under review and plans have been developed for automation of service delivery measurement standards for DMA benefits. Also in FY 1979, plans were made to reconstitute the Advisory Committee on Cemeteries and Memorials.

Administrator Cleland places a special wreath at the Vietnam veterans plaque in observance of the start of Vietnam Veterans Week, Memorial Day, May 28, 1979.

At the end of the fiscal year, the National Cemetery System consisted of 108 cemeteries totaling over 8,000 acres and 33 soldiers' lots and plots totaling 29 acres. Nearly 3,000 acres of land have been developed for burials with gravesites available in 57 national cemeteries. In addition, family-related burials continued in occupied and reserved graves in closed national cemeteries. Columbarium niches were utilized in the Los Angeles National Cemetery for cremated remains.

In FY 1979, interments in VA national cemeteries increased seven percent over FY 1978, bringing the total number of interments in national cemeteries under VA jurisdiction close to 1.5 million. At the end of FY 1979, there were approximately 177,000 gravesites developed for burials in existing cemeteries, and 74,000 reserved gravesites. Potential gravesites, including undeveloped acreage in three cemeteries not yet open for interments, totaled nearly 2.7 million.

Comprehensive planning provided for the orderly development of acreage and gravesites in VA national cemeteries, with 20 acres developed for gravesites in FY 1979. DMA continued to evaluate existing cemetery land and areas adjacent to national cemeteries for the purpose of expansion where gravesites are needed. In FY 1979, 2.5 acres were transferred to the VA for the expansion of the Port Hudson National Cemetery in Louisiana, while actions to transfer land at four other national cemeteries were nearing completion.



National POW-MIA Recognition Day, Washington National Cathedral, July 18, 1979

Historic Preservation

The Department of Memorial Affairs continued an active program of renovation or restoration of national cemetery buildings eligible for listing on the National Register of Historic Preservation. Projects were undertaken at the Wood National Cemetery in Wisconsin, and the Bath National Cemetery in New York, to restore buildings considered essential to the original character of the cemetery.

Where lodges can no longer be utilized effectively for cemetery operations, a program of leasing to nonprofit local organizations ensures preservation of these buildings. In FY 1979, the lodge at the Port Hudson National Cemetery was leased to the State of Louisiana for use by the Louisiana Department of Parks and Tourism.

Construction Projects

The FY 1979 program included major construction and/or development projects at five new national cemeteries as shown in the table.

National Cemetery	Project	Cost (In thousands)
Calverton	Design and develop 71 Acres (Phase 2, partial); construct service building complex	$ 2,576
Indiantown Gap	Develop 100 acres; construct permanent entrance and approach road; relocate transmission lines (Phase 2)	5,021
Quantico	Develop 75 acres (Phase 2)	4,400
Region IV	Design 50 acres for interments and administration and service buildings (Phase 1)	353
Region V	Design 50 acres for interments and administration and service buildings (Phase 1)	350
		$12,700

Headstones and Markers

Headstones and markers are furnished for the graves of eligible veterans and their dependants interred in National and Post Cemeteries, including those under the jurisdiction of the Departments of the Army, Navy, Air Force, or Interior. In addition, headstones and markers are furnished for the unmarked graves of eligible deceased veterans interred in private cemeteries.

Of the more than 250,000 applications processed during the year, 10 percent were cancelled during the eligibility determination or resolution process. The accompanying table provides detailed statistics on applications for FY 1979.

Applications for Headstones/Markers	FY 1979	FY 1978	Percent Change
Original	247,995	249,707	−0.7
Private cemeteries	209,004	210,647	−0.7
National Cemeteries	38,991	39,060	−0.1
Replacements	6,838	5,617	+21.7
Total Applications	254,833	255,324	−0.2
Cancellations	24,212	25,989	−6.8
Net Applications	230,621	229,335	+0.6

During FY 1979, 230,600 headstones and markers were ordered from 12 contractors at a total cost of $10,382,763 or an average unit cost of $45.02, including transportation and Parcel Post costs. Of these, 81 percent were sent to private cemeteries, the remainder being placed in government owned cemeteries. Included were 440 memorial headstones or markers for nonrecoverable decedents, three group burial headstones, and 43 special Medal of Honor headstones or markers ordered under the Medal of Honor Memorialization Project, first approved as part of the VA Bicentennial Year activities. A total of 562 Medal of Honor headstones or markers had been furnished under this program by the end of FY 1979. The accompanying table contains detailed statistics on the procurement of headstones and markers for FY 1979:

Type Headstone/Marker	Number Ordered	
	FY 1979	FY 1978
Total	230,600	225,435
Upright marble	39,668	43,624
Flat marble	9,544	9,304
Flat granite	64,972	66,656
Flat bronze	116,342	105,783
Flat bronze-special design	71	67
Group burial granite	3	1

Headstones and markers are shipped to gravesites throughout the world; during FY 1979, more than 2,700 were shipped to destinations outside the continental United States.

The accompanying table illustrates the overseas destinations of headstones and markers shipped in FY 1979, actions which require a variety of complex transportation arrangements:

Destination	Number	Destination	Number
Alaska	168	Jamaica	1
American Samoa	3	Japan	1
Australia	3	Mexico	5
Canada	49	Newfoundland	1
Canal Zone	12	Nicaragua	1
Costa Rica	2	Nova Scotia	1
Cuba	2	Philippines	469
England	4	Puerto Rico	1,292
France	1	Seychelles Islands	1
Germany	9	Scotland	1
Guam	19	Virgin Islands	16
Haiti	1		
Hawaii	663		
Ireland	6	TOTAL	2,731

Several events had an impact on the processing of headstones and markers in FY 1979:

(1) The Veterans' Housing Benefits Act of 1978, Public Law 95-476, permits the VA to award a monetary allowance for placement of a non-government headstone or marker in a private cemetery in lieu of a government marker. This monetary allowance is not to exceed the average cost of a government furnished marker, which in FY 1979, was established at $50. The headstone or marker monetary allowance is administered by the Department of Veterans Benefits, but DMA verified 13,742 Applications for Reimbursement of Headstone or Marker with their records to prevent duplication of this benefit.

(2) The same law also provided that government furnished headstones or markers may be of any material requested if the material is determined to be cost effective and, in the case of a national cemetery, aesthetically compatible with the area of the cemetery in which it is to be placed.

(3) The Veterans' Disability Compensation and Survivors' Benefits Act of 1978, Public Law 95-479, provided that memorial headstones or markers shall be furnished, when requested, to commemorate veterans who die after service and whose remains have not been identified, have been buried at sea, or have been determined to be nonrecoverable. Previously, only those ''dying in service'' were eligible for a memorial marker.

(4) On April 26, 1979, following the General Counsel's guidance, a change in policy was instituted, permitting the inclusion on a government headstone or marker of any emblem reflective of a religious belief or nonreligious belief, at government expense. The three religious emblems historically inscribed at government expense continue to be included on government headstones and markers when requested.

State Cemetery Grants Program

The newest program of the Department of Memorial Affairs — the State Cemetery Grants Program — came into existence with the enactment of the Veterans' Housing Benefits Act of 1978, Public Law 95-476. A section of that Act authorized the Administrator of Veterans Affairs to make grants to states for the establishment, expansion, and improvement of state veterans' cemeteries. An appropriation of $5 million was authorized for this purpose for FY 1980.

The program has generated a great deal of interest among the states. At the end of FY 1979, 19 states had requested grant application instructions; seven had either enacted or were working on appropriation bills for veterans' cemeteries; and two states had submitted applications for grants.

Administration and Management

Comparative Highlights

Item	FY 1979	FY 1978	Percent Change
Total appropriations (millions)	$19,901	$18,515	+7.5
General Operating Expenses	632	582	+8.6
Benefit programs	13,158	12,275	+7.2
Medical programs	5,660	5,169	+9.5
Construction programs	452	489	7.6
Total employment	226,084	228,885	-1.2
Minority (full time)[1]	59,694	61,797	3.4
Women	116,954	117,840	-0.8
Veterans' preference	87,130	89,223	-2.3
Vietnam era veterans	38,805	37,351	+3.9
Disabled veterans	13,601	13,722	-0.9
Records holdings (thousands of cubic feet)	1,487	1,516	-1.9
Forms and form letters	12,177	11,487	+6.0
Appeals filed	61,097	66,464	-8.1
Appeals disposed of	61,066	59,048	+3.4
Appeals allowed	13,921	14,644	-4.9

[1] As of May 31

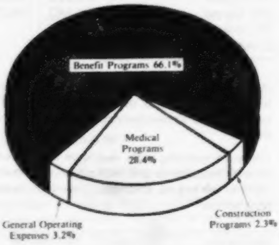
Agency Funding

Congress appropriated nearly $20 billion in FY 1979 to fund benefits and services administered by the VA. This represents an increase over FY 1978 of nearly $1.4 billion, with corresponding increases in all program areas except construction. While new budget authority for construction decreased, construction obligations increased over 1978 by $93.8 million, or 42 percent.

Monthly compensation and pension benefits were paid to some 5 million veterans and survivors in 1979 totaling $10.5 billion, an increase of $1 billion over 1978. During 1979 a rate increase of 7.3 percent was provided under the Compensation Program, and the Pension Program was revised and improved by enactment of new legislation. This new legislation provides for automatic annual cost-of-living adjustments in pension payments. Total pension payments increased by $310 million in 1979.

More than $5.6 billion was appropriated for medical care and treatment of veterans in 1979, an increase of $490 million over 1978. Medical and prosthetic research efforts to improve the delivery of health care to veterans and to improve the treatment of the disabilities and diseases most common to veterans were funded by a $123 million appropriation in 1979. Inpatient care and treatment were provided to over 1.3 million veterans in 1979 and over 17 million outpatient care visits were made. The increased medical workloads were manageable due to a reduced average inpatient census as VA hospital turnover rates increased and lengths of stay became shorter in 1979.

VA FY 1979 APPROPRIATIONS



Staffing Management

During FY 1979 the VA introduced improved methods for relating staffing, workloads, and program impacts in the budget process. In addition, improved productivity measures were completed in some major VA activities. Further, a prototype Resource Allocation and Management System was designed to support staff allocation in the Department of Medicine and Surgery (DM&S).

Improved methods for analyzing staffing requirements were introduced into the budget process through the development by the Office of Manpower Programs of independent workload forecasts. The workload forecasts were converted into staffing requirements using statistical analysis for past years, factoring in productivity changes, and identifying related program impacts. By uniformly applying these staffing criteria to all programs, VA's top management was provided an objective tool for making trade-off decisions on staffing levels among competing budget proposals.

The Department of Memorial Affairs' productivity indicators were reviewed and modified to reflect productivity trends more accurately. This effort included changing the measures of productivity for cemetery maintenance, and headstone and marker application processing. As a result of these changes the Department of Memorial Affairs was the first major element of the VA to employ a single data base for budgeting, program management, Federal Productivity Measurement Project reporting, and quarterly status reporting to VA management.

The DM&S Resource Allocation and Management System monitors individual hospital personnel levels, relates workloads to personnel levels, and provides comparative data for hospitals in like groups. Testing was initiated to determine the system's operational uses in monitoring and allocation of staff to VA hospitals, and to identify areas in need of further refinement.

Personnel Management

Federal personnel management was presented with its greatest challenge in nearly a century on October 13, 1978, when the Civil Service Reform Act became law. This landmark legislation revamps the civil service in an effort to build a more effective government.

Effective and timely implementation of the Reform Act in the VA required priority attention by the Office of Personnel. New personnel programs had to be developed, many existing ones had to be modified, and an array of ancillary systems had to be designed to support them all. Significant actions during FY 1979 included:

- Conversion of 250 senior executives to a new VA Senior Executive Service (an agency conversion rate of 99.6 percent).
- Development of a performance appraisal system for senior executives and formulation of plans for a similar system for Merit Pay employees.
- Establishment of Executive Resources Boards and Performance Review Boards for the Senior Executive Service (SES).
- Design of programs to identify, select, and train SES candidates and provide developmental opportunities for SES incumbents.
- Comprehensive review of personnel management authorities exercised within VA and substantial redelegation of them to lower management echelons.
- Incorporation into agency policy of grade and pay retention provisions of the Act, authority for noncompetitive appointment of 30 percent service connected disabled veterans, probationary period for new supervisors and managers, and revised rules governing adverse actions and labor relations.
- Orientation and training of all facility directors and personnel officers on Civil Service Reform and its implications for the VA.

In other personnel matters, special attention was given to strengthening the position classification and job grading programs which cover approximately 130,000 General Schedule and 40,000 Federal Wage System employees in the VA. The VA's implementation of the grade and pay retention amendments of the Civil Service Reform Act will further assist VA in improving these programs while also protecting employees from the adverse impact of corrective classification actions.

The VA conducted a flexitime experiment at selected field facilities under the provisions of Title 5, U.S.C. Evaluations indicate flexitime is generally feasible, that it is liked by most employees, and in many instances improves service to veteran beneficiaries. Also, as a result of the Federal Employees Flexible and Compressed Work Schedules Act of 1978, selected VA field facilities were offered an opportunity to experiment with compressed workweek schedules which vary from the traditional 40-hour workweek.

On-site reviews of personnel management activities were conducted at 35 field installations during the fiscal year. The majority of these were included in an Office of Personnel Management (OPM) agency-level review conducted as a joint OPM/VA effort, with VA assuming lead responsibility in nearly half of the reviews. Although overall results of the review by OPM are not yet available, preliminary indications are that programs involved with hiring and utilizing disabled veterans, other handicapped individuals, and Vietnam era veterans have been particularly effective.

Staffing

During the fiscal year, about 66,000 employees were hired in the VA. On the whole, there were sufficient applicants available to meet the agency's staffing needs. However, a general shortage of trained health care personnel in many areas of the country necessitated extensive recruitment efforts to attract highly qualified individuals for medical and paramedical positions.

Recruitment efforts included advertising at the national and local levels; attending national professional conventions, job fairs, and career days; conducting an active college liaison program; making direct mail contacts with prospects; and establishing and maintaining good relationships with professional organizations.

Outreach recruitment efforts in FY 1979 were significantly improved by the development of a new *VA Recruitment Bulletin* which lists shortage category positions. The *Bulletin*, published twice monthly, is sent to national offices of veterans' organizations, veterans' organization representatives at VA installations, and employees who advise and counsel veterans on benefits and rehabilitiation. The *Bulletin* is also sent to over 2,000 educational institutions and organizations involved in veteran and minority employment. Also produced was a new VA pamphlet which promotes employment for Vietnam era and disabled veterans by providing case histories of successful disabled VA employees in a wide variety of occupations. The pamphlet outlines the various special hiring authorities which facilitate employment of these veterans. It received wide distribution throughout the VA, other government agencies, and veterans' organizations.

These recruitment efforts contributed to generally improved staffing of health care facilities. For example, the number of nurses on VA rolls on September 30, 1979, totaled close to 29,000, a slight increase over the previous year. This continues a rising trend in VA employment of nurses over the past several years, although some medical centers continue to experience difficulty in recruiting nurses.

In response to the Federal Employees' Part-Time Career Employment Act of 1978, the VA has encouraged the use of part-time workers wherever possible resulting in a 4.5 percent increase during the past fiscal year. This program will continue to be emphasized throughout the agency.

The special pay provided by the VA Physician and Dentist Pay Comparability Act of 1975 appears to have had a positive impact. During the four-year period following enactment, the full-time physician work force increased approximately 11 percent, while losses were 17 percent lower than during the four-year period preceding enactment. Recruitment is, however, expected to continue to be difficult, particularly for scarce specialties.

The accompanying table shows the numbers of various health care professionals on the rolls at the end of the past two fiscal years.

Position	September 30, 1979			September 30, 1978		
	Total	Full Time	Part Time	Total	Full Time	Part Time
Physician	10,464	6,281	4,183	10,387	6,407	3,980
Dentist	912	880	32	907	879	28
Podiatrist	98	45	53	79	42	37
Optometrist	71	31	40	62	27	35
Nurse	28,881	26,828	2,053	28,666	26,716	1,950
Nurse Anesthetist	552	495	57	544	498	46
Physician Assistant	354	304	50	294	269	25
Expanded Function Dental Auxiliary	4	4		5	5	

The VA has been authorized by the Office of Personnel Management to appoint rehabilitation technicians in drug and alcoholism rehabilitation units without civil service competition. To be eligible for such appointments, applicants must be former drug or alcoholic patients who have been rehabilitated through a prescribed treatment program. As of September 30, 1979, there were 294 rehabilitation technicians employed under this authority. Of these, 194 had veteran preference, including 87 Vietnam era veterans.

Employment of Veterans

The VA continued to be one of the major Federal employers of veterans; new hires in FY 1979 included 17,208 veterans. As of September 30, 1979, 17 percent of all VA employees were Vietnam era veterans and 6 percent were disabled veterans. Veterans comprised 71 percent of all VA male employees; of these, 47 percent served during the Vietnam era and 17 percent were disabled.

The VA made full use of the Veterans Readjustment Appointment (VRA) extension provisions of Public Law 95-520 which gave greater flexibility in hiring VRA eligibles. The VRA authority allows eligible Vietnam era veterans to be hired directly, then serve a two-year period during which they also pursue training or education. Following successful completion of these requirements, VRA appointees may be converted to competitive civil service status. The 51,501 Vietnam era veterans hired by the VA under this authority since it was established in April 1970 represent more than a third of the VRA appointments made throughout the Federal government.

By hiring over 5,700 under this authority during the past year, the VA exceeded its goal under the FY 1979 VRA Action Plan submitted in response to the President's initiative. The VA ranks number one among large Federal agencies in the use of the VRA authority. Those converted to competitive status in this fiscal year numbered 2,413, for an overall total of nearly 16,000 such conversions since the program began. To help meet short-term staffing needs, the VA temporarily employed 3,300 Vietnam era veterans in FY 1979.

The Civil Service Reform Act authorizes Federal agencies to employ veterans with service connected disabilities of 30 percent or more noncompetitively in positions for which they qualify. Although this authority is relatively new, the VA has hired 166 veterans under this program. Training and work experience were also provided to 79 disabled veterans and 28 were converted noncompetitively to career-conditional appointments under Civil Service regulation 315.604 during the fiscal year.

Because of the nature of VA's mission in serving veterans, a sizeable number of Vietnam era veterans serve in VA jobs where they meet, work closely with, and provide services to other Vietnam era veterans and their beneficiaries. About 64 percent of the VA veterans' benefits counselors are Vietnam era veterans, as are 42 percent of the veterans' claims examiners. Vietnam era veterans also comprise nearly half of all prosthetic representatives, 39 percent of the vocational rehabilitation specialists, and 21 percent of the medical technicians. Among the first VA representatives a patient encounters are the medical administrative assistants serving in medical center admission areas, 23 percent of whom are Vietnam era veterans.

Executive Development and Training

Major steps taken to meet Civil Service Reform Act requirements for developing the agency's executive personnel resources included (1) a program for systematic selection and development of Senior Executive Service (SES) candidates; and (2) a program for continuing development of incumbent SES officials. These two new programs are integral parts of the VA Four-Tier System for Executive and Management Development initiated last year to provide comprehensive training and development activities for four different management levels.

Course curricula for the new programs, as well as for the other elements of the Four-Tier System, are being designed to be responsive to actual managerial training needs at various VA organizational levels as identified through a professional training needs assessment. One source of needs assessment information was a comprehensive survey of some 800 randomly selected VA executives and managers.

Other Four-Tier programs launched during the fiscal year achieved a high degree of success. Included in these new offerings were: Policy and Legislation Seminars in which 86 Central Office senior executives and field station directors participated in a week-long series of briefings at the Capitol on the VA policy process and the complexities of VA legislation; Executive Forum Luncheon Programs, held in conjunction with the Policy and Legislation Seminars, at which 245 executives participated; and Self-Assessment and Planning Courses for New VA Managers. Approximately 350 supervisors at various field facilities were given labor relations training. Management training courses were provided throughout the country at universities and the VA Regional Medical Education Centers, and Civil Service Reform Act seminars were held for about 500 field facility directors and personnel officers. In total, about 1,800 executives and managers participated in these and other programs fully or partially funded by the VA Executive Training Center.

Labor Management Relations

Approximately 165,000 VA employees are represented by unions. The Federal Labor Relations Authority has ordered consolidation of 234 American Federation of Government Employees local units of recognition into a single national bargaining unit covering 118,000 VA employees, and thus representing the largest single unit in the Federal government. The VA's first national union contract for this unit will be negotiated in calendar year 1980. Two other unions, the National Association of Government Employees and the National Federation of Federal Employees, have also petitioned the authority to consolidate their local units of recognition into national bargaining units.

Ten additional labor organizations represent other VA employees at local field facilities and nearly all unionized VA employees are covered by negotiated agreements. The VA also deals with several national labor organizations on a national consultation basis.

Employee Recognition

With an aim similar to the original effort in 1977-1978 --To reiterate VA's commitment to serve veterans competently, courteously, and with compassion, -- another "VA -- May I Help You" campaign was initiated with a slightly different emphasis. The focus was on recognizing employees who personify this commitment in their work, thus encouraging others to do the same. This recognition has been made more meaningful by a temporary change in the incentive awards program which permits use of cash instead of payment in the next salary check. Early indications are that supervisors are applauding the cash award provisions as a positive employee morale factor and stations seem to be responding with originality and enthusiasm reminiscent of the first campaign.

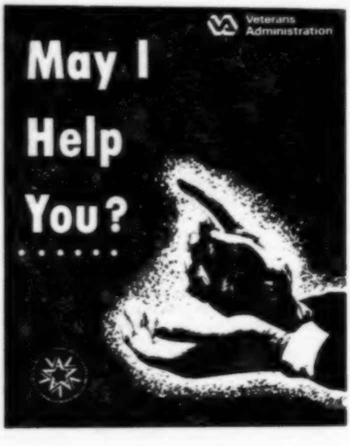
VA employees, responding to the emphasis on cost reduction, saved the Federal government almost $4.6 million, which is an increase of over a million dollars from last fiscal year. Awards for these contributions totaled $247,823.

Two employees at the VA Medical Center (Lake Side) Chicago, shared $2,500 -- the largest award given for an employee suggestion. Dr. Yeongchi Wu, Assistant Chief, Rehabilitation Medicine Service and Harold J. Krick, Corrective Therapist, developed a new method for treating below-the-knee amputation which resulted in greater patient comfort, less psychological trauma, and the quick return of patients to family and jobs.

Thirty-eight employees received personal letters from President Carter for their achievements which saved $5,000 or more. These and 29 other employees were awarded the Administrator's Cost Reduction Contributor certificate for ideas saving at least $1,000. Altogether over 10,000 suggestions were received and 3,316 were adopted.

During FY 1979, quality increases were awarded to 5,102 employees in recognition of high level performance. The VA also presented 8,551 special achievement awards for superior performance and for special acts or services.

Two highlights of the year were the receipt of the National Civil Service League's Career Service Award by Dorothy L. Starbuck, the Chief Benefits Director, and the presentation by former Congressman Olin E. Teague of the first award given in his name. The recipient was Dr. Myron G. Eisenberg, psychologist from the Cleveland Medical Center, for developing a sex education counseling program for the spinal cord injured. This new VA award recognizes outstanding contributions by an employee to the rehabilitation of war disabled veterans, and will be awarded annually.



Equal Employment Opportunity

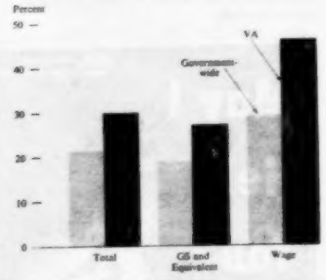
To confirm their support for the principles of equal opportunity, the Administrator and top agency officials signed the VA's Statement on Human Goals which affirms that, "We of the VA must continually strive to serve our veterans and their dependents and survivors with compassion, competence and sensitivity; and to pledge fair and equitable treatment for our employees and volunteers."

Minority Employment

During the year, the total full-time employment of minorities in the VA increased from 30.2 percent to 30.3 percent. Blacks comprised 25 percent of the work force; Hispanics, 3 percent; American Indians, 0.2 percent; and Orientals, 1.7 percent. Total full-time employment throughout the VA decreased by 4 percent, while employment of minorities decreased by 3.4 percent. Minority women comprised 16 percent of the work force.

Governmentwide, minority employees represented 22 percent of the total full-time work force in November 1978. At that time 19 percent of the General Schedule and equivalent employees were minority, as were 29 percent of the wage employees, and 14 percent of the employees in other pay systems.

MINORITY EMPLOYMENT
VA COMPARED TO FEDERAL GOVERNMENT
FY 1979



In the VA, minorities accounted for 27 percent of all employees in General Schedule and equivalent positions in FY 1979. Minorities were generally well represented among Title 38 positions, with 18 percent of the nurses, 19 percent of the physicians, and 3.5 percent of the dentists. In all instances, these figures represent increases from the previous year. Minority employment under the wage system increased from 46.1 percent to 46.2 percent.

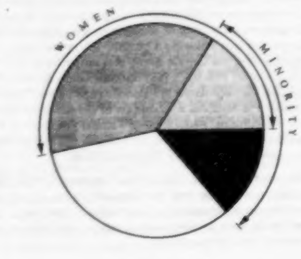
Agencywide, minorities accounted for 31 percent of the accessions, 28 percent of the promotions, and 20 percent of the separations during the past year.

Advances were realized by minorities at all except the highest grade levels (GS 16-18). At the GS-9 level and above 16 percent of the work force were minority employees, up from 15 percent the previous year. At GS-15 and equivalent 16 percent were minority employees, up from 14 percent in FY 1979.

Minorities held 20 percent of all VA supervisory positions, and their average grade rose from 5.8 in FY 1978 to 6.0 in FY 1979. Minorities were represented in several top policymaking and managerial positions in the VA. For example a minority member served as Assistant Administrator of the Office of Human Goals, 13 minority members served as directors of field facilities and 8 were assistant directors.

As of May 1979, 30 percent of veterans employed by the VA were minorities: 20,479 blacks, 3,018 Hispanics, 199 American Indians, and 632 Orientals. Among the Vietnam veterans, 31 percent were minorities: 8,598 blacks, 1,762 Hispanics, 87 American Indians, and 391 Orientals.

VA EMPLOYMENT
WOMEN AND MINORITIES
FY 1979



(Data as of May 1979.)

Employment of Women

VA continues to be a leader in the Federal government in providing equal employment opportunities for women. As of May 31, 1979, women occupied 104,168 or 53 percent of all VA full-time positions. Women received 56 percent of all VA promotions, 52 percent of all training, and occupied 36 percent of all supervisory positions.

In white collar positions, women accounted for 59 percent of the total, and occupied 60 percent of positions at grades 7 through 12 and equivalent. At GS-13 and equivalent and above, women held 15 percent of the white collar positions as compared with 12 percent at the end of FY 1978.

Employment and advancement opportunities for women in the VA continue to increase. During the year the Administrator appointed several women to high level policy making positions in the Department of Medicine and Surgery, including an Assistant Chief Medical Director (ACMD) for Research and Development, a Director of Medical Research Service, and a Deputy ACMD for Academic Affairs. Women also served in policymaking positions as Directors of Pathology, Nursing, and Dietetics. In addition two women are medical center directors, nine are assistant directors and four are chiefs of staff. Other FY 1979 appointments of women included an Assistant Administrator for Administrative Services and a Director of Management Services.

In the Department of Veterans Benefits, the Chief Benefits Director is a woman as are a regional office director and an assistant director.

The Administrator also appointed two women to serve on the White House Interdepartmental Task Force for Women, and two to serve on the Interagency Task Force on Women in Federal Law Enforcement.

Part-time employment of women continued at a high rate in a wide range of professional, administrative, and technical positions in various occupational specialties and at many grade levels. At the end of FY 1979, there were 11,644 women employed on a part-time basis.

Employment of Disabled Veterans and Handicapped Individuals

The VA is strongly committed to programs designed to achieve an environment in which disabled veterans and handicapped individuals receive fair consideration for employment and advancement based on their ability. This approach produced the following accomplishments as of the end of FY 1979:

- A work force in which 12 percent of employees are self-identified as handicapped compared to a Federal average of 7 percent by the most recent report;

- A total employment of 6 percent disabled veterans, exceeding the government-wide level of 5 percent.

Some of the methods utilized by the VA to employ disabled veterans and handicapped persons are Schedule A appointments for severely physically handicapped persons, veterans readjustment appointments, non-competitive appointment for 30 percent compensable disabled veterans, consideration of nonstatus applicants including handicapped individuals, and conversion of Schedule A severely handicapped and mentally retarded employees. VA's flexitime and part-time work schedules were of special help to handicapped individuals. Nearly 1,500 handicapped persons were employed on a part-time or intermittent basis.

In support of the continued recruiting effort by VA of handicapped persons a 21-minute color videocassette, ''A Different Approach,'' has been added to VA's film library. In addition, stations are providing as part of basic supervisory training ''Successful Supervision of Handicapped Employees.''

Mr. Hilliard A. Carter, a Social Work Associate and a Vietnam Era veteran at the VAMC, Hines, Illinois, was honored in official ceremonies in October 1979 in Washington, D.C. as one of the ten Outstanding Handicapped Federal Employees of the Year. As additional evidence that ''ability counts,'' other handicapped employees achieved the following distinctions during calendar year 1978: 3,682 promotions, 1,425 special achievement awards, 673 quality increases, 526 suggestion awards, 58 performance awards, and 196 special citations.

Hilliard Carter, one of the Outstanding Handicapped Federal Employees of 1979, and his wife, Ollie

Automatic Data Processing

Virtually all VA beneficiaries are affected by the agency's extensive computer network and related facilities. To improve timeliness and accuracy of service, efforts are continuing to replace older computer systems with newer equipment and methods. Most prominent is development of VA's ''Target'' system, designed to take full advantage of the most up-to-date automated data processing (ADP) equipment and techniques to modernize processing and handling of the compensation, pension, and education systems.

During FY 1979, the first phase of Target implementation was successfully completed. This phase includes the capability for on-line, immediate access to the Compensation, Pension, and Education (CP&E) data base of approximately 13 million veterans' records, and to the Beneficiary Identification and Records Locator Subsystem. Access to these files from all regional offices and the Records Processing Center is accomplished instantaneously through video display terminals, allowing regional office personnel to provide immediate responses to inquiries from the veteran. The first phase also provides for some limited update functions.

During FY 1980, the second major phase of Target implementation will be accomplished allowing quicker and more efficient claims processing.

The VA operates six data processing centers in processing financial, CP&E, insurance, construction, medical, and other applications. These centers utilize a computer network of

27 systems with an additional two on order to support these programs. In addition, the Department of Medicine and Surgery has approximately 250 computers installed at individual medical centers in support of unique applications, with an additional 163 on order or being installed. The Office of Construction has three mini-computers, the Controller's Office one, and the Board of Veterans Appeals has one system.

As the primary means of maintaining continuity of government operations in event of a disaster, vital magnetic tapes containing information on veterans are duplicated and shipped to an underground depository on a cyclic basis. While this is an important part of the agency's emergency planning procedure, a number of security initiatives are employed to back up computer operations and prevent compromising personal records.

The Beneficiary Identification and Records Locator Subsystem (BIRLS) located at the Austin DPC is interfaced with the Target system for on-line inquiry purposes. Because of the projected increases in the nationwide workload for BIRLS, computer equipment at Austin will be upgraded on an interim basis in FY 1980. Plans are also underway to redesign BIRLS to accommodate additional requirements which will provide better information and service to the Departments of Veterans Benefits, Medicine and Surgery, and Memorial Affairs. The redesign of BIRLS will be a continuing effort through FY 1982.

The conversion of the Insurance System for processing on the equipment purchased for use by the Target system is well underway and will continue into FY 1980. Consolidation of bill printing from two locations to the Philadelphia DPC was undertaken in FY 1979 and was completed by the end of calendar year 1979. Since the converted system is intended for interim use, initial plans are underway to redesign it for on-line inquiry. This redesign will provide improved service to those 4.8 million veterans who currently maintain policies with the VA. The redesign of the Insurance System will continue through 1983.

The VA maintains a number of separate computer systems which support the loan program. Consolidation and redesign of these systems are under consideration because of the economic benefits which could be derived and the potential for improved service to veterans.

Computer System Improvements

Efforts continued to increase the effectiveness of VA's computer centers through hardware changes, additions and enhancements to facilities and sites, and improved training capabilities.

Improvement and expansion continued in microfilm technology, a process which replaces paper output with less expensive, more compact film records and reports. Form outlays are being used to project document images on microfiche. Data generated by a computer system is processed and projected on the desired areas of the overlay, giving the appearance of a photographed paper document. This procedure reduces processing time and eliminates the need for redundant titling of commonly used output data. During FY 1979, microfilm output at the Austin DPC increased 16 percent over FY 1978, producing almost 2.5 million microfiche containing more than 320 million frames. The data on those microfiche would require more than 107,000 boxes of one-part paper to produce hard copy printouts; in microfiche form, the storage requirement is about the same as 260 boxes of paper.

Procurement and installation of Uninterruptible Power Supply (UPS) systems continued at VA computer sites to protect against electrical damage and minimize computer disruptions. The Austin and Hines DPCs have full-scale systems in operation, with diesel generators included at Austin to supply computer electricity during commercial failures. In addition, procurement of a full-scale UPS system was initiated to replace the "interim" system installed at the Philadelphia DPC. A plan was developed to improve the system operating at the Los Angeles DPC.

A terminal-oriented minicomputer system was selected to automate the input functions of the Centralized Accounting for Local Management system at the Austin DPC to improve the efficiency and accuracy of standard financial information provided for monitoring station fiscal operations.

The VA continued its program to provide greater opportunities for handicapped persons who wish to pursue careers in data processing. Use of special computer terminals for the blind continued to open new career opportunities for the visually impaired. These special terminals which can produce "Braille embossed" printing as well as communicate with the computer, allow a blind programmer to perform the same functions as a sighted person.

A concerned effort began in FY 1979 to improve the project management capabilities of senior and mid-level VA project managers by adopting a modern and well-structured approach to the planning and administration of small-, medium- and large-scale ADP system development projects. The new methodology will result in better communications between agency users and project managers and decrease the risk in development of new VA data processing systems.

Medical Applications

Fiscal year 1979 was one of significant activity in the VA for application of ADP technology to medical problems and requirements.

The Automated Clinical Laboratory System is installed at eight sites throughout the nation. All results of laboratory tests are entered on the clinic profile, providing a history which is accurate, complete, and readily available for physician use. The system may also be used to control scheduling of patient visits to clinics and admissions to VA medical centers. During FY 1979, the plans to upgrade the equipment at the Wadsworth VA Medical Center were completed. Plans for FY 1980 call for the upgrade of equipment at four of the other sites. The upgraded systems will permit facilities to utilize the automated outpatient clinic scheduling capacity in addition to the automated capabilities of clinical laboratory and admissions and dispositions.

The Automated Prescription Processing, Labeling, Editing and Storage (APPLES) system is an on-line outpatient prescription processing system which has successfully eliminated large backlogs in pharmacies at VA medical facilities in the Southern California Region. The system utilizes a common data file consisting of over 123,000 patient records, 351,000 prescription records, and a drug file with over 9,700 entries. During FY 1979, two pharmacies were added to the APPLES system to bring the total to seven. Network and terminal equipment system enhancements were completed this year to satisfy increasing workload demands resulting in significant benefits to the veterans, doctors, and hospital management by reducing pharmacy prescription waiting times, drug expenditures, and administrative overhead.

The Fee-Basis Medical and Pharmacy Program allows authorized veterans to receive medical services from individuals or organizations. The VA compensates participating members for services performed, and pays the veteran for travel expenses incurred for the visit. Fee basis processing for 77 VA medical centers is centralized at the Austin DPC. To effect more timely payments, the Advanced Records System is utilized to transmit data. About 13,500 fee-basis transactions are processed daily at Austin.

Veterans' Benefits Applications

The Department of Veterans Benefits also has many systems, both nationwide and local, which are processed at the six data processing centers. Many of these systems were improved during FY 1979 through redesign, reprogramming, and faster processing in a third-generation computer environment.

To implement the Post-Vietnam Era Veterans' Educational Assistance Act of 1977 the VA developed a banking and payment system. At present, the banking system is computerized and the payment system is manual. The banking system maintains a history of the contributions made to a fund by service personnel and the various units of the Department of Defense and passes data to various users, i.e., Treasury for payments, accounting for general ledger and payment processing, and BIRLS for identification of program participants. Originally installed in December 1977 at the Austin DPC, this system was transferred to the Hines DPC during FY 1979 to process within the Target Central Data Base.

The Centralized Accounts Receivable System (CARS) provides the status of compensation, pension, education, and loan guaranty accounts receivable. The system processes on a daily basis and maintains data on over 500,000 accounts with a dollar value in excess of $400 million.

Other Applications

In FY 1979, an effort was initiated to automate the major operating functions in the Department of Memorial Affairs. The Record of Interment file will be microfilmed for security and locator purposes and a master data base will be created to facilitate computerization of related applications. These innovations will provide better and faster service, eliminate backlogs, insure priority of records, and more effectively utilize present resources.

The construction program over the next two fiscal years is expected to more than double in size to approximately $800 million by FY 1982. To deal with this growing program, greater reliance must be placed on automated systems to improve program/project scheduling and cost control. During FY 1979, a Distributed Processing System was installed for the Construction Management Information System (CMIS). This system is operational at the Office of Construction on a mini-computer which is linked to the computer at the Washington DPC. Data entry to and query of the CMIS data base is accomplished via a cathode ray tube on the minicomputer with overnight updating of the master file occurring at the Washington DPC. CMIS provides current data in a timely fashion which helps to control project schedules effectively and to alleviate cost overruns resulting from schedule changes.

Utilizing an enhanced ADP system, all critical Zero Base Budget (ZBB) ranking functions for FY 1981 were processed in the VA budget conference room in Washington by use of digital communications lines to computers at the Hines and Washington DPCs. Timely, high quality printed reports were obtained for review during the ranking sessions by use of a telecommunications transfer of report data from the Hines DPC to the Washington DPC where the required photocopier was located. Magnetic tape was used to input the final results of the VA ranking sessions to the Office of Management and Budget automated budget system.

Work was completed during FY 1979 to transfer the payment and processing function of the Consultant and Attending system from the Hines DPC to the Austin DPC. The system provides payments for private sector personnel who perform consultant/attending services at 169 VA medical facilities. The transfer consolidated personnel payment processing at Austin and resulted in a modern, technically upgraded system.

A minicomputer hardware/software system was developed at the Central Office location of the Board of Veterans Appeals and was implemented in April 1979. The Veterans Appeals Control and Locator System provides rapid response to inquiries about the status of veteran's appeal or current location of a veteran's claim case file, and furnishes periodic reports concerning claims file management and control.

A management information system is being developed for the Inspector General (IG) Office of Audit which will provide summary reports of VA audit activities for Congress, other government agencies, and the IG. Implementation during October 1980 is anticipated.

A General Counsel Administrative Tracking System is being developed to control litigation, agency legislation, and legal opinions. While this system is being developed for Central Office, a preliminary study is being conducted for a system that can be employed at all District Counsel offices.

Telecommunications

In FY 1979, VA programs relied upon electronic telecommunications for support in many areas. Of major importance was the formation of a special ''Earthquake Assessment

Task Force'' by special request of the Administrator. Telecommunications equipment at all VA facilities in California was reviewed to determine the feasibility of VA participation in state and Federal emergency plans, identify current communications resources, determine whether equipment could survive a disaster, and determine additional equipment requirements.

Data Transmission

Use of highly sophisticated terminal hardware utilizing the latest data communications technology continues to play a vital part in serving veterans' needs.

The VA developed the technical specifications for replacement terminal system equipment at all VA stations on the Advanced Record System in order to meet increasing demands for rapid transmission of data from VA facilities to data processing centers.

A computerized electrocardiogram (ECG) data transmission network was installed in Medical District 2. The Albany VA Medical Center (VAMC) is the host site for the computer serving six remote VAMCs via data communications facilities. Plans are being developed for the installation of ECG systems in other Medical Districts.

Eighty-three VAMCs are participating in the National Library of Medicine's Medline System. Through keyboard-printer and display data terminals interfaced with the Medline data base at Bethesda, Maryland, VA physicians have immediate access to biomedical bibliographic citations which assist in treating patients.

Technical research and evaluation of terminal devices to assist persons with sensory impairments were conducted. As a result, terminals have already been installed at some VA facilities with more projected during 1980.

Telephone Service

During FY 1979, eight obsolete telephone systems were replaced and contracts were signed for ten new telephone systems at medical center locations. The uniform bid evaluation procedures used by VA were revised to increase competition and reduce costs. The telephone systems at those medical centers which are not included on the five-year replacement plan were re-engineered to provide adequate telephone service. Selected service improvements were installed in leased systems, including toll call diverting, telephone accessed radio and audio paging, and centralized dial dictation.

The use of VA toll-free telephone facilities by veterans to obtain benefits information increased 17 percent. This growth in the use of 800 service and foreign exchange lines required installation of additional circuits and terminal equipment.

A study was conducted to identify efficient and economical telephone terminal equipment for use in answering incoming veterans' calls at smaller VA regional offices. As a result, 23 automatic call sequencing units were purchased and installed in selected locations.

The use of facsimile (FAX) equipment at VA facilities continues to grow. VA now has FAX equipment at all medical centers and at selected regional offices which utilizes the Federal Telecommunications System intercity voice network to facilitate the transmission of information required to assist veterans.

Closed Circuit Television System

The use of closed circuit television (CCTV) throughout the VA has become commonplace. Although installation of large studio type systems has been reduced, updating of existing systems continues. New and more sensitive lightweight cameras and video recorders now allow the use of television for previously difficult tasks such as low light level security, patient observation in intensive care units, etc. The use of television for these purposes increased during the year. While CCTV cannot replace the nurse or security guard, it is a valuable adjunct and the demand for this tool is expected to increase during FY 1980. Our test facility is actively testing, evaluating and identifying television and other types of communications equipment to meet VA needs at the lowest possible cost.

Radio

The popularity and demand for versatile radio equipment continues to increase. Two-way radios are used by maintenance personnel and security forces, while radio pagers are relied upon for locating doctors and other essential personnel, helping assure responsive and timely delivery of health care. The use of citizens' band radios for patient rehabilitation has increased and, while forbidden for use in the conduct of VA business, they are used in VA vehicles to obtain information on road conditions where adverse weather conditions are likely to be encountered.

The VA's use of the radio frequency spectrum continues to increase. Since other government agencies are also increasing their use of radio and availability of new frequencies is limited, sharing of frequencies, particularly in metropolitan areas, is becoming a necessity. As a result, development of a VA National Frequency Assignment Plan was undertaken to consolidate all VA radio systems on four frequencies, if possible. Reducing use of the frequency spectrum will provide advantages to the VA, such as the possibility for exchange of radio equipment, emergency netting with neighboring facilities, and reducing the complexity of frequency management. Implementation of this plan will be accomplished as radio systems are replaced, and will take several years for completion. The VA currently operates radio systems on 1250 frequency assignments, compared to 1000 frequency assignments at the end of FY 1978.

Nurse Call Communications

New and replacement nurse call systems are the most up-to-date available and are procured through the competitive bid process to assure that they meet facility requirements at the lowest possible cost. Investigations into ways of providing necessary nurse call services at reduced cost is continuing, including an in-depth analysis of an integrated wide-band coaxial cable. A system of this type could provide simultaneous paths for transmission of nurse call signals and signals of most other telecommunications used at a medical center. An initial study was inconclusive, but the concept is promising and investigations of this medium will continue in the coming year.

Construction

The Office of Construction is responsible for the planning, design, and construction of new buildings, additions, alterations, and major repairs of existing buildings and structures at nearly 280 medical centers, domiciliaries, nursing homes, and over 100 cemeteries located throughout the United States. This office also is responsible for real property management which includes the acquisition and disposal of real estate, and space management in VA facilities and those GSA facilities which are occupied by VA in either government-owned buildings or government-leased space.

Contracts

The VA's total construction obligations for FY 1979 amounted to $317 million. This level of construction obligations is the highest in modern VA history. Of this total, five major architect-engineer contracts amounting to nearly $10 million were awarded and include the replacement medical centers at Bay Pines, Florida, and Seattle, the nursing home at Washington, D.C.; a bed renovation project at Little Rock, Arkansas; and a clinical addition and modernization at Oklahoma City. Among the construction contracts, ten were awarded at a total cost of $108 million. These include phases of the Bay Pines and the Martinsburg, West Virginia, replacement medical centers; nursing homes at Gainesville, Florida, and Livermore, California; air conditioning projects at Coatesville, Pennsylvania; and Knoxville, Iowa; a clinical addition at Reno; an outpatient addition at Nashville; a 200-bed domiciliary at Dayton, Ohio; and a clinical and ambulatory care and laboratory addition at Salt Lake City.

Design work has begun on the Baltimore, Little Rock, and Seattle replacement medical centers. In addition, the Bay Pines, Martinsburg, and Richmond replacement medical centers are under construction. The Portland, Oregon/Vancouver, Washington, medical center and nursing home are planned for design in FY 1981 and construction in FY 1982.

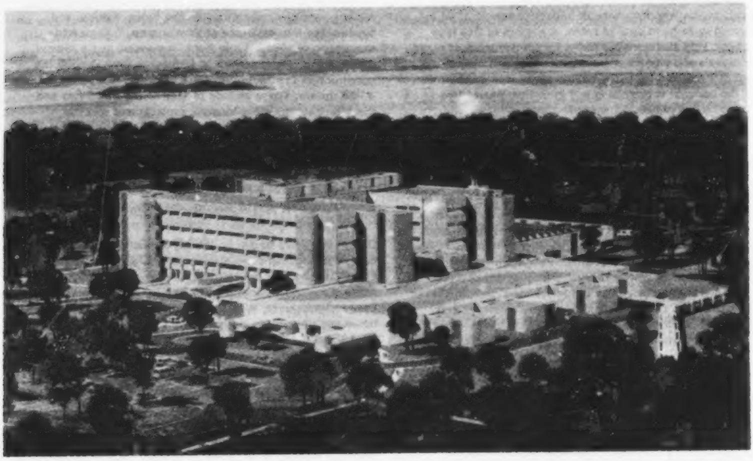
Major construction projects completed in FY 1979 include air conditioning projects at Sepulveda, California, Lexington, Kentucky, Lincoln, Nebraska, and Salem, Virginia; outpatient clinics at Long Beach, California, and Cincinnati, Ohio; a replacement hospital at Columbia, South Carolina; a research addition at Jackson, Mississippi; a new wing addition at Madison, Wisconsin; a 150-bed nursing home at Palo Alto, California; and a 200-bed domiciliary at Wood, Wisconsin.

CONSTRUCTION STATUS

Description	Total		Completed		Under Construction		Authorized But Not Under Construction	
	Number	Estimated Construction Cost (million dollars)	Number	Estimated Construction Cost (millions dollars)	Number	Estimated Construction Cost (million dollars)	Number	Estimated Construction Cost (million dollars)
Totals - **	829	1953.52	186	143.06	404	832.94	238	980.51
Replacement & Relocation Hospitals	11	976.12	0	-0-	5	453.33	6	523.00
Modernization	9	43.47	4	14.94	3	8.14	2	20.78
Cemeteries	33	21.11	6	8.58	5	5.58	17	6.94
Nursing Home Care Units	16	77.19	2	5.38	10	39.03	4	32.78
Research & Education	17	29.46	3	10.50	6	5.50	6	13.37
Domiciliaries *	4	34.19	1	6.40	1	7.12	2	20.70
Other Improvements	730	771.79	170	88.46	300	304.36	200	380.80
Air Conditioning	10	115.33	7	31.53	5	48.01	2	35.78
Other	721	656.46	163	56.93	360	256.33	198	333.21

* *Table not prepared for Domiciliary Projects*

***Totals not exact due to rounding*



520 Bed Replacement Hospital, VAMC Bay Pines, Florida

Construction Research

The construction research and development program encompasses a wide range of architectural and engineering projects in health care building technology. The projects are accomplished by contracts with private firms and individuals, educational institutions and other federal agencies, or by the VA staff. Findings are implemented in the VA construction program and reports are published and made available to others in the public and private sectors.

Twenty-two projects were underway during FY 1979. These included projects on fire safety design, national cemetery planning criteria, plumbing criteria, smoke control techniques, support to the Energy Engineering Program involving emergency technology, solar energy applications, computer software applications to technical subjects, and evaluation of new building materials and products.

Major research study projects completed during the year included (1) Improving the Techniques for Development of Space Planning Criteria, (2) Guidelines for Building Energy Monitoring and Control Systems, (3) Fire Hazards in Hospitals from Smoke and Toxic Gases, and (4) Development of New Planning Criteria for National Cemetery Memorial Centers.

Energy Engineering

The VA views the current and projected energy crises as requiring a two-part solution. First, systems using fossil fuels must be made more efficient through the specification and selection of the most energy-conserving equipment compatible with the application. Second, we must use renewable sources of energy to the maximum extent possible.

With respect to conserving fossil fuels, the VA has put the first commercial version of the Annual Cycle Energy System into operation at Wilmington, Delaware. This energy efficient system is powered by electricity but uses only one-third of the fossil fuel required to heat and cool a comparable building using conventional systems.

We also have installed a device called the "heat extractor" on our boiler plant at Albany, by which the energy previously wasted through the boiler stack is now recovered and used to heat the hospital. This device will save an estimated 100,000 gallons of oil each year resulting in an impressive four-year payback. The success of this research project has led to the funding of 48 additional heat extractors at other VA installations with an anticipated savings of six million gallons of oil annually.

To meet Executive Order 12003, we feel that the use of renewable energy sources is mandatory. Our current analysis of those sources indicates that the direct use of solar energy holds the most potential, and we have expended much effort in the pursuit of solar assisted systems for our new buildings. We presently have four systems in operation which save an estimated 40,000 gallons of oil each year and 21 projects under construction which will save an additional 200,000 gallons of oil annually. We are continuing this program for the future and are presently designing 13 projects with an anticipated annual savings of 400,000 gallons of oil.

In looking to the future we are continuing with research and design of other renewable energy systems. In Albuquerque, New Mexico, we have funded a solar steam generation project which will provide two million pounds of steam to supplement steam produced by conventional, fossil fuel fire boilers. At Washington, D.C., solar energy and waste heat from a diesel driven air-conditioning chiller will regenerate a desiccant which dehumidifies the air. This is an example of using current solar energy technology for building cooling.

Real Estate and Space Management

During FY 1979 the VA acquired 5.2 additional acres of land adjoining the National Memorial Cemetery of the Pacific in Hawaii and 2.5 acres of donated land adjoining Louisiana's Port Hudson National Cemetery.

There were more than 100 outgrants such as leases, licenses, and permits authorizing the use of VA real property to individuals, organizations, and Federal and local government agencies during the fiscal year.

The VA paid $55 million to the General Services Administration for 9.2 million square feet of rental and building service. A portion of this rental cost was for five new satellite outpatient clinics and the Boston drug and day treatment center. Included in this year's direct VA leases were six leases which will serve as drug and mental hygiene clinics.

Barrier-Free Design

For the past 20 years the VA has been a leader in eliminating architectural barriers. The first Design Detail DD-46 "Facilities for the Handicapped" was adopted in April 1959, three years prior to the publication of the American National Standards Institute (ANSI) specifications for making buildings and facilities accessible to the physically handicapped. The ANSI standards were adopted in 1961 and reaffirmed in 1971, and have since become the minimum standard guidelines accepted by most Federal agencies. VA standards and regulations as contained in the current Construction Standard CD-28 "Accommodations for the Physically Handicapped," have been consistently more stringent than the ANSI standards used by other agencies and are considered in some areas to exceed the revised ANSI standards to be issued in 1980.

During the past year a program was established in which architectural barrier compliance inspectors have been trained and a survey of all existing medical centers, excluding the seven to be replaced, was made to identify and to place in order of priority barrier removal projects for funding and scheduling. It is a goal of the agency to remove all barriers throughout the VA medical system regardless of the age of the facility, and whether or not it falls under the jurisdiction of the Architectural Barriers Act of 1968.

State Veterans' Homes

The Office of Construction is responsible for rendering technical assistance to the Office of the Assistant Chief Medical Director for Extended Care in reviewing and evaluating project submissions of grant applications from state veterans' homes. In the past year over $15 million was granted for 35 state home projects, and an additional 25 state home grant projects have been submitted for review and evaluation, bringing total grants close to $39 million.

Management Improvement

During 1979, the VA continued with the agency-wide program planning process introduced in FY 1978. The process has three objectives:
(1) the development of long-range planning assumptions and trends,
(2) formulation of the Administrator's priorities and guidance, and
(3) the development of an agency five-year plan.

It is designed to meet the needs of top management without replacing or interfering with individual internal planning and management systems of the VA departments and staff offices. Planning emphasis is directed to the following priority areas: Vietnam era veterans, service connected veterans, aging veterans, spinal cord injuries, consumer affairs, ambulatory care, alcohol and drug abuse, rehabilitation, provision of burial sites, health care information system development, and manpower.

The current planning approach is designed to provide management oversight of all department/agency efforts directed toward these areas regardless of which functional programs or budgeting decision units they fall within.

To assure the VA program goals and objectives are met in the most efficient and effective manner, the agency regularly conducts program evaluations, special studies, and management reviews. The issues identified in these evaluative efforts, together with recommendations for corrective action, are correlated with and supportive of the planning process.

Two studies of special significance were begun in FY 1979. One concerns the long-term disabilities resulting from being held prisoner of war. This study, required by Public Law 95-479, is scheduled to be completed in April 1980. The other is a study ordered by the President and conducted for the VA by Louis Harris and Associates, to determine public attitudes toward Vietnam era veterans. The results of an advance survey were released in November 1979. Additional Harris studies of the general public, Vietnam era veterans, educators, and employers are being conducted and the results are expected in early 1980.

A number of special studies were completed during FY 1979. Especially significant examples include studies of VA Spinal Cord Injury Centers, and admissions/outpatient operations. Also a report was completed detailing the results of the VA's eight-month experiment with flexible working hours (flexitime).

Seven program evaluation reports were submitted to Congress in FY 1979, pursuant to Section 219, Title 38, U.S.C. These reports addressed the following VA programs: Alcohol and Drug Dependence Treatment, Spinal Cord Injury, Vocational Rehabilitation for Disabled Veterans, Specially Adapted Housing for Disabled Veterans, Reimbursement for Burial Expenses, Burial Flags, and Exchange of Medical Information. At the close of the year, 23 additional program evaluations were in various stages of completion. Under the law, evaluation of agency programs is to be accomplished on a continuing basis. As programs are re-evaluated, data describing the impact of delivery of services to beneficiaries will be updated and made available to managers for their use in administering VA programs. These data will also provide feedback for development of the five-year plan and will pinpoint areas needing special studies to correct deficiencies before they become major problems.

As a result of the VA-sponsored National Rehabilitation Conference, held in Washington, D.C., in FY 1979, attention was focused on ways to upgrade and modernize rehabilitation services provided veterans. This will be a continuing effort on the part of the VA. A task force was established following the 1979 conference to develop policy recommendations which are expected in 1980.

With the signing of Executive Order 12160, entitled, "Providing for the Enhancement and Coordination of Federal Consumer Programs," the VA consumer affairs program received increased emphasis. A Consumer Affairs Staff was formed to coordinate agency consumer activities and a complaint/compliment reporting system was developed to strengthen the agency's ability to stay informed of the concerns of veterans and other interested groups on a nationwide basis. The consumer program is expected to improve upon VA's existing mechanisms for dealing with veterans, dependents, and the general public. A draft agency consumer program was developed in accordance with the Executive Order for publication in the *Federal Register* for public comment prior to being put into final form early in 1980.

An Operating Instruction providing guidance and procedures for the implementation of OMB Circular A-109, Major Systems Acquisitions, was published. The instruction provides for a structured approach in acquiring major systems, directed toward fulfillment of an agency mission, entailing allocation of large resources, and deserving of special management attention at the highest level.

Important agencywide improvements were made during FY 1979 in VA Emergency Planning activities, including the areas of earthquake hazard mitigation, installation of supplementary communications equipment in high-risk areas, and improved coordination procedures on the local, state and Federal levels. Additionally, procedures for a systematic oversight of VA field station disaster exercises and new emergency training concepts and methods were initiated during FY 1979.

Records and Information Management

A moratorium on the destruction of veterans' medical records began in July 1979 because of the need to review retention policy in light of recent concern about the possible medical effects of exposure to radiation, herbicides, and other environmental contaminants. No records can be destroyed until new disposal authorizations have been developed. A Medical Administration Service task force was established in FY 1979 to review medical record retention standards and to develop options regarding this sensitive series of records.

During the period October 1, 1978 through September 30, 1979, VA's year-end records holdings decreased by about 29,000 cubic feet or 2 percent for a total close to 1.5 million cubic feet. The volume of new records created during FY 1979 (under 150,000 cubic feet) was approximately half of the FY 1978 figure. This decrease can be attributed to the fact that about 112,000 fewer new claims folders were created than were retired or destroyed. Also, 140,000 cubic feet of less active or inactive records were transferred to low-cost storage for an increase of 46 percent over FY 1978. An additional 45,000 cubic feet of records were retired to Federal Archives and Records Centers. The volume of records destroyed under the authority of the National Archives and Records Service was nearly 111,000 cubic feet.

Significant progress was made in VA's continuing effort to reduce the costs of records handling and storage through the use of microform technology. Engineering drawings and specifications documenting the construction of VA facilities nationwide and numbering over 120,000 were converted from paper to microform, freeing nearly 1,600 square feet of office space. In conjunction with this effort a reconstituted ADP index to the drawings was created which permits a faster simplified access to the file.

During this same period, the Department of Memorial Affairs completed plans for microfilming more than two million Records of Interment. The new system will permit rapid access to any record and will considerably reduce the space required for the present file. Total cost avoidance is estimated to be $50,000 annually.

The Department of Veterans Benefits continued its project to develop improved systems for the storage and retrieval of records. Loan Guaranty records have been assigned first priority for analysis which should result in the installation of a more cost efficient, space saving records system.

In compliance with the President's Reporting Burden Reduction Program, the VA has reduced the number of annual respondent hours required for the completion of VA forms and reports by 15 percent (1.4 million manhours). This was achieved by various actions, primarily by eliminating or revising forms and form letters. The VA inventory of public use forms and reports has remained relatively stable for FY 1979. On September 30, 1979, there were 12,177 different VA forms and form letters in use, of which 37 percent were standardized for VA-wide use. During the year, 73 standardized forms and form letters were eliminated as no longer necessary, 179 were created to meet new requirements, and 497 were up-dated and improved.

During FY 1979 the agency continued to cooperate with the Department of Defense and other government agencies in the exchange of records and information. Public Law 95-479 required the VA to undertake a study of former

American prisoners of war. As part of the study effort, it was essential to identify as many of these individuals as possible by obtaining records and data on more than 100,000 individuals from the National Archives and Records Service and the Department of Defense (DOD).

During the year VA and DOD also cooperated in exchanging information and records relating to radiation exposure during atmospheric nuclear testing in the 1950s, and to the effects of the herbicide Agent Orange.

In October 1979 a memorandum of understanding was signed between the VA and military service finance centers which establishes an annual program for reconciling VA's master compensation/pension disability payment records with military retired pay records. This agreement will result in more accurately coordinated payments to military retirees and a significant reduction in the error rate in VA and military records.

The Department of Veterans Benefits continued to expend its word processing capability during FY 1979. One additional center was established, bringing the total in operation to 1 in Central Office and 52 in field stations. These word processing centers provided nearly 12 million pieces of correspondence during FY 1979, an increase of 297,000 over FY 1978. This increase was achieved with a slight decrease in employment. The conversion from low speed (150-350 wpm) to high speed (535 wpm) automatic typewriters and increased use of repetitive letters contributed significantly to the increase in productivity. Approximately 1.1 million patterns were prepared, a 7 percent increase over FY 1978. Over 100 automatic typewriters are now in use primarily for preparation of repetitive and semi-repetitive correspondence.

United and American Airlines issued discount coupons that would result in a 50 percent fare reduction when used for round-trip travel taken during the period July 1 to December 15, 1979. Government agencies were advised by the General Services Administration to collect coupons distributed by these airlines to government employees traveling on official travel orders (since the coupons were government property), and to use the coupons on longer, more expensive trips because of limited availability. The total savings realized by the VA through the use of these coupons during FY 1979 was $63,300.

The Office of Management Services sends copies of approved proposed and final VA regulations simultaneously with their publication in the Federal Register to service organizations with a strong interest in veterans' affairs. Copies of these documents are also forwarded to the congressional veterans' affairs committees for their immediate information.

Because of the increase in the volume of VA regulations, this office has initiated a thorough analysis of regulation writing and Federal Register submission procedures in the VA. The purpose of the analysis is to define ways to improve the quality of regulations and submissions while reducing the time necessary for their preparation. The new procedures, which will include appropriate office system support, will increase the productivity of this function considerably.

Reports Management

During the fiscal year, 59 new report plans were approved and 57 were eliminated, for a net increase of 2. The inventory of reports consists of 503 approved internal VA plans and 120 approved interagency plans for a total of 623. A study of the total information needs of the Office of Human Goals was completed, and a similar study for Engineering Service was in progress at the close of the year.

Improvement in the Patient Treatment File resulted in approval of nine new reports and a reduction in the number of copies of four others. Reports produced by this system continued to improve in terms of timeliness and accuracy.

The Automated Management Information System (AMIS) is an agencywide system designed to meet the statistical reporting needs of VA Central Office management. The system also provides reports to other government agencies. During FY 1979, AMIS accommodated approximately 700 requests for new reports or changes to existing reports. Accomplishments during the fiscal year include:

- incorporation of the Medical Care Distribution Cost Reports into AMIS;
- addition of the Inspector General, Department of Memorial Affairs, and the Office of Manpower Programs as users;
- preliminary development of a comparison of planned and actual obligations by program and appropriation; and
- further progress in the redesign of input processing functions.

Financial Management

An agencywide cash management policy was implemented in line with the President's Reorganization Project. For FY 1979, the savings in interest and administrative costs which directly relate to this policy amounted to $1.6 million.

The Direct Deposit/Electronic Funds Transfer program for recurring compensation and pension payments increased to 721,604 participants during FY 1979. This represents a participation rate of 15 percent at the end of the second full year of the program. Participation is increasing at an average of 20,000 accounts per month. The program was extended during FY 1979 to cover VA employee salary payments and began with participation of over 49,000 employees. Current statistics show that approximately 21 percent of all employees participate in the Direct Deposit/Electronic Funds Transfer program. Under this program a benefit or salary payment is sent directly to a designated financial institution, and credited to the beneficiary's or employee's account. This often provides a security advantage as well as a convenience to the individual. The government realizes considerable monetary savings, and both the government and the payees benefit from a reduction in the number of lost or stolen checks.

Audits and Investigations

As a means of addressing new initiatives required by the Inspector General Act of 1978, the Risk Analysis Staff was established just prior to the start of FY 1979. Responsibilities of this staff include performing vulnerability assessments of existing VA systems and programs to determine primary weaknesses permitting fraud, waste, or abuse; evaluating legislative and regulatory proposals; and receiving and processing employee hotline complaints. The Staff's contributions in FY 1979 began with coordination of agency vulnerability assessments developed by program officials in response to a request from the Office of Management and Budget. As a result of this effort, 562 vulnerabilities in 96 program/activities were identified. Three independent vulnerability assessments involving Education and Pension Programs were completed, the most significant finding of which was the projected potential payment of $2.7 million to ineligible beneficiaries in the Education Program. Vulnerability assessments of the VA medication distribution system and quality assurance features of the Pension Benefits Program were in process at the close of the fiscal year. Improvements were suggested for 11 of 77 legislative and 11 of 25 regulatory proposals. Of the 650 employee hotline complaints received during the year, 440 were closed, and about a quarter of these were judged to be at least partially founded.

Audit activities during FY 1979 included eight preinstallation reviews; 38 special initiatives for fraud, waste and mismanagement; and 325 cyclical audits, all of which resulted in total cost avoidances of $20.4 million. The completed audits of contractors, grantees, and other external organizations participating in VA programs resulted in recommended cost adjustments of $9.3 million. In addition, twelve audits were completed of Predischarge Education Program participants with collection action recommendations totaling $6.7 million.

A system has been developed and put in place to monitor the resolution of audit findings and the collection of audited funds disallowed in accordance with Office of Management and Budget (OMB) Circular A-73 (Revised) and the Inspector General Act of 1978.

An audit universe was established which groups organizational, program, and functional entities according to the VA's major activities, and identifies administration and management activities with VA-wide applications. In all, some 1,620 entities have been identified.

Investigation activities were directed at two objectives of the Inspector General: to seek out fraud, waste and abuse, and to conduct investigations of complaints of serious criminal and administrative irregularities. The number of investigations related to these two objectives during FY 1979 were 585 and 71, respectively. In addition, the office processed 3,778 personnel security clearances and 475 FBI arrest records, analyzed 173 documents for possible forgeries or misrepresentation; and reviewed and referred 713 FBI reports.

Audiovisuals

The VA produced five motion picture films during the fiscal year. The film titled " . . . A Grateful Nation Remembers" documents ceremonies at Arlington National Cemetery on Veterans Day, November 11, 1978, and features the President placing the Presidential Wreath at the Tomb of the Unknowns and delivering his Veterans Day address to the nation from the amphitheater. The film "Wherever We Find Them" emphasizes the value of handicapped individuals' participation in physical recreational athletic activities, and explains VA programs available for the training and improvement of athletic skills. This film was awarded the CINE Golden Eagle Certificate by the Council on International Nontheatrical Events for story theme effectiveness, production excellence, and its suitability to represent the United States and American cinematography in international film festivals abroad.

"They Served-We Remember and Honor" records the 1979 Memorial Day Ceremonies at Arlington National Cemetery, highlighting the Vietnam Veterans Week observances there. The film features the Administrator placing Presidential Wreaths at the Tomb of the Unknowns and at the Vietnam Veterans Plaque and giving his Memorial Day address to the nation. Two other films completed during this period were "Mobile Home Loans" an informative presentation of the VA's mobile home loan program, and "Team Leader Module," a training film for use by the Department of Medicine and Surgery.

The audiovisual activity maintains the VA's centralized motion picture film library consisting of 780 titles and 3,659 prints for use in medical and scientific research, and in orientation, training, information, and rehabilitation programs. During FY 1979 nearly 6,000 distributions were made to VA facilities, other Federal and state agencies, veterans' organizations, educational institutions, and professional and scientific groups.

Six television spot announcements were produced during the fiscal year to inform veterans of benefits available to them under the law. The spot, "Time," reminds veterans to use their GI Bill eligibility before it expires. "Priority Card" explains identification of service connected disabled veterans which enables them to get top priority at VA medical centers. "Welcome Home" was a Vietnam Veterans Week salute to veterans.

The exhibits activity produced 12 new exhibits, and 222 new and existing exhibits were presented for a total of 1,382 presentation days at VA facilities, veterans' organization conventions, educational institutions, and professional, medical, and scientific meetings. The exhibit "Extended Pelvic Lymphadenectomy for Prostatic Cancer" was awarded second prize in the scientific exhibit category at the 1979 American Urological Association Convention for text on clinical research in urology and presentation effectiveness.

Presidential Memorial Certificate Program

The Presidential Memorial Certificate Program honors the memory of honorably discharged deceased veterans. The VA administers the program by issuing certificates which bear the President's signature and express the country's grateful recognition of the veteran's service in the armed forces to the next-of-kin of the deceased veteran. Eligibility for the certificate is determined by the VA when notice of the veteran's death is received and next-of-kin information is available. Certificates may also be issued upon request to other relatives and friends of the deceased veteran.

Over 3.5 million certificates have been issued since the program was initiated in March 1962. The VA now issues an average of 920 certificates daily. A total of 231,000 were issued during FY 1979.

Legal Matters

The need for legal advice and assistance has increased steadily in recent years. Legal workloads increased 16 percent and the number of attorneys increased 5 percent in FY 1979.

Medical malpractice claims under the Federal Tort Claims Act increased 15 percent in FY 1979, while funds paid out in settlement of administrative tort claims under $2,500 increased 25 percent to $237,000 in FY 1979.

Collection of reimbursements for medical care increased to $8.3 million in FY 1979. Of that total, $3.9 million was collected from third-party tort feasors, over $230,000 under medical insurance policies, and $4.2 million for the treatment of industrial injuries. These collections are impeded by some laws and practices such as some state no-fault statutes which preclude payment of hospital costs to the Federal government. Similarly, numerous insurance companies have drafted their health insurance policies to preclude payment to the Federal government for these costs. VA has submitted to the Congress proposed legislation intended to preclude the exclusion of the Federal government as a claimant.

In the area of education litigation, several issues of major concern were resolved in FY 1979, and some new areas of controversy have arisen:

(1) Decisions favorable to the government's position on class-session or ''seat-time'' requirements were rendered in two cases which had been appealed to Circuit Courts of Appeals. Both cases were remanded to the appropriate lower court for consideration of constitutional issues not previously reached. Another case is currently in the appellate process.

(2) Litigation which had been pending since 1977 involving school liability for overpayments to veterans and dependents resulted in a decision by the Court of Appeals upholding the school liability statutes and VA procedures for determining school liability. The court also held that VA school liability procedures are not subject to the Administrative Procedures Act.

(3) Audits of the Predischarge Education Program (PREP) found substantial surpluses of funds which may be recoverable from schools which participated in this program. Administrative collection is being pursued, but it appears that litigation will be necessary to effect recovery of the surplus funds from a number of these PREP schools.

Recently adopted procedures for referral of delinquent education overpayments of $600 and above to the U.S. Attorney for prosecution have resulted in referral, through FY 1979, of over 54,000 cases representing debts of nearly $62.5 million.

Under authority recently granted the VA, a test program has been instituted to determine the effectiveness of pursuing education overpayment debts in amounts less than $600. These cases, which cannot be referred to GAO or the Department of Justice, were not previously pursued beyond administrative efforts. The test involves 10 selected cities and will cover a period of approximately one year.

Several suits have been instituted seeking to prevent VA and VA guaranteed lenders from using non-judicial foreclosure procedures permitted by state law, and to require VA to institute a larger scale program of purchasing defaulted home loans. Two U.S. District Courts have rendered conflicting opinions in these cases, and both decisions are under appeal. Several suits have also been instituted by holders of VA guaranteed loans challenging VA's right to deny liability under the guaranty where there has been a forgery on the note or other loan papers. The holders, who received an assignment of loans from the original lender, claim that legally the VA is only permitted to establish defenses against the original lender. The VA regulations, which deny all liability in forgery cases, have been upheld by the Federal courts in cases decided to date.

The agency continued its policy on judicial review which, briefly stated, is that court review should be permitted of all constitutional questions arising under its administration of veterans' programs. The VA also does not object to court review in cases involving claims for benefits if Congress desires such review. The agency strongly recommends, however, that the extent of any court review be provided in legislation specifically designed for the VA and codified in Title 38, U.S.C. Proposed legislation on this subject is now before the Congress. Legislation to change VA adjudication procedures, provide judicial review of VA benefit decisions, and allow reasonable attorney fees has been introduced in Congress and has passed the Senate.

In spite of the finality statute proscribing judicial review of VA benefit decisions (Section 211(a), Title 38 U.S.C.), there was increased litigation to challenge internal VA procedures. Significant cases in this regard involve disabilities allegedly caused by exposure to the defoliant ''Agent Orange'', forfeiture of benefits due to fraud, and recoupment of overpaid benefits by setoff against proceeds of National Service Life Insurance. None of these cases has resulted in any changes in the established legal precedent, but final outcome is still pending.

Increased attention was given to the matter of long-term effects of exposure to toxic substances, principally herbicide Agent Orange with its contaminant, dioxin, and to radiation resulting from nuclear weapons testing. Approval of a charter for an Advisory Committee on the Health Effects of Herbicides was obtained and the Committee held two meetings. A Steering Committee on Agent Orange was also organized, comprised of the various elements of the VA concerned with this problem.

An Interagency Task Force on Compensation for Radiation-Related Illness was established by the White House for the purpose of examining criteria for compensating individuals exposed to radiation produced by nuclear weapons testing. Originally, the task force was to look at the experiences of the civilian population which resided in areas located downwind of nuclear weapons testing sites. This function was subsequently expanded to include assessing criteria for compensation of workers and veterans who may have been exposed to radiation and later developed health problems.

The VA has been actively participating in the work of this task force.

There are many unresolved questions concerning the increased risks of leukemia or other cancers as a result of exposure to low-level ionizing radiation. Agencywide adjudication instructions were issued to facilitate the handling of disability compensation claims by veterans who contend that they were exposed to radiation as a result of their presence at atmospheric testing of atomic weapons during the period 1945-1962. All reasonable doubt will be resolved in the favor of veterans.

Litigation alleging deprivation of the rights of psychiatric inpatients as a result of restrictions on their freedom while hospitalized, and seeking promulgation by the VA of patients' rights regulations was initiated during FY 1979 and is now pending. Prior to the filing of that litigation, draft regulations guaranteeing patients' rights and clarifying VA's role in the treatment of civilly committed patients were under study. That process, which is near completion, involves a critical review of patient rights in terms of patients' therapeutic needs, protection of patients and others from harm, and the unique role of state law in civil commitment.

The VA has liaison offices in the Senate and the House of Representatives, and maintains close working relations with congressional members, committees, caucuses, and their respective staffs. During FY 1979, the VA responded to 15,000 pieces of correspondence, approximately 46,000 telephone calls, and 5,400 walk-in visits, an increase in workload of 2 percent. Congressional members are informed on VA budgetary, legislative, and program initiatives; changes in VA medical centers and regional offices; and new developments in the VA construction program. VA also continues to provide congressional offices with information and advice regarding the rights and benefits of their veteran constituency.

Inquiries involving the Freedom of Information Act, Privacy Act, and VA laws which specifically deal with certain types of VA information continued to create a high volume of legal and administrative issues. In order to address these issues, a Freedom of Information Act/Privacy Act (FOIA/PA) Office was established in March 1979 under the purview of the Office of the General Counsel. Creation of a FOIA/PA Office was recommended by VA studies, which reported that a single office with oversight authority over all components of the VA was necessary for effective, efficient, and uniform compliance with the detailed and voluminous requirements of these laws and related provisions. Establishment of such an office was subsequently directed by the President and the Office of Management and Budget (OMB).

Since March, the FOIA/PA Office has worked in coordination with VA departments and staff offices in reviewing department system notices and information management policies and practices, and assessing agency compliance with OMB guidelines pertaining to agency computer security. The FOIA/PA Office also conducts training programs on the requirements of the Acts and works with other Federal agencies and OMB to review and upgrade Privacy Act management practices within the Federal government.

Legal actions pertaining to procurement of construction supplies and services increased in FY 1979. Agency budgets in this area have increased approximately 10 percent since FY 1978 and legal questions in this activity have become more complex. Construction projects must comply with all Federal, state, and local environmental laws and regulations and require an environmental assessment and a determination whether there is a conflict with emissions, water, and toxic standards. There are also increasing questions of flood plain management, use of wetlands, and preservation of historic sites.

In the past fiscal year the General Counsel was involved in 12 environmental impact analyses and several hundred assessments, and has conducted environmental public hearings for two new medical facilities.

Several actions have been taken to curb the increasing incidence of criminal conduct occurring at VA Medical Centers. These actions include cooperating with a private security force in patrolling parking lots jointly used by several medical center complexes, acquiring additional surveillance equipment for use inside hospitals for theft control, revising search authority regulations for discovery of life-threatening weapons or substances in the possession of hospital patients, and exploring means to control pilferage from the hospitals by employees, patients, and visitors. VA has sought and received congressional attention to the problem and will seek legislative assistance as appropriate.

Several General Counsel opinions were issued during FY 1979 interpreting requirements of the Civil Service Reform Act of 1978, including questions of congressional intent, and inclusion of officials of the separate statutory personnel system of the Department of Medicine and Surgery in the Senior Executive Service. Questions of statutory interpretation notwithstanding, a large majority of eligible employees responded favorably to an invitation to convert to the newly developed Senior Executive Service. Although three appeals of agency decisions in the conversion process regarding pay levels and eligibility were taken before the Merit Systems Protection Board, the agency actions in each case were affirmed. The VA believes that the positive response and the system as implemented will enable both the agency and individual employees to benefit fully from the program.

Title VII of the Civil Service Reform Act changed the procedures for litigating unfair labor practice complaints filed by employee unions. As the Federal Labor Relations Authority became organized and staffed, new policies for labor litigation in the agency have evolved. The new policies have increased the involvement of local VA District Counsels in unfair labor practice cases. A new training program for District Counsel lawyers in personnel and labor law was designed and conducted immediately after the Authority became operational. Refocusing labor litigation at the local level has made the process both more cost efficient and more responsive. Labor relations law is also affected by an increasing trend toward consolidation of VA employees' labor unions. This trend has necessitated exploring the legal aspects of national bargaining. Allocating more labor litigation to District Counsels has freed central staff resources to meet these problems.

The Act authorizes employees to contest agency disciplinary actions under grievance procedures which have been negotiated by unions and the employing agency. Several negotiability appeals await decision of the Federal

Labor Relations Authority whether such grievance procedures should also extend to disciplinary actions taken by the Department of Medicine and Surgery under express provisions of Title 38, U.S.C.

The Ethics in Government Act of 1978, Public Law 95-521, contained a number of provisions requiring monitoring of compliance. VA is complying with these provisions, principally ensuring that personnel in Grades GS-16 or the equivalent and above timely file appropriate financial statements as mandated by the Act; providing, upon request, advice on various aspects of the Ethics Act; and assisting in the development of agency policy in the designation of personnel who are to be subject to post-federal employment restrictions of the Act.

Appellate Review

Claimants not satisfied with determinations made by VA field offices may file a written notice of disagreement with the office taking the action. If after reviewing the case the field office is not able to grant the benefits sought, it sends the appellant a statement of the case outlining the issue, the evidence of record, the pertinent laws and regulations, and the reason for the decision. If the appellant, after reading the statement of the case, still disagrees with the field office, he or she can submit an appeal to the Board of Veterans Appeals (BVA). The field office reviews the case again and if it still cannot be resolved to the satisfaction of the claimant, the case is sent to the BVA for review and final decision.

Appellate Processing	FY 1979	FY 1978
Appeals pending, start of period	46,116	37,262
Undocketed, in field offices	33,625	25,792
Docketed, in BVA	12,491	11,470
Filed during period	61,097	66,464
Settled in field offices	30,844	28,186
Allowed	9,494	10,208
Closed	15,592	12,783
Withdrawn	5,758	5,195
Submitted to BVA	34,124	36,655
Decided by BVA	34,972	35,634
Allowed	4,431	4,456
Remanded for further action	4,761	4,772
Withdrawn	217	174
Denied	25,563	26,232
Appeals pending, end of period	47,832	46,116
Undocketed, in field offices	36,189	33,625
Docketed, in BVA	11,643	12,491
Summary Final dispositions	61,055	59,048
Allowed	22.8%	24.8%
Closed	25.5%	21.6%
Withdrawn	9.8%	9.1%
Denied	41.9%	44.5%

Despite a slight drop in new appeals filed and in the number of cases reaching the BVA in 1979, appellate activities remained high. Final dispositions in appealed cases rose above 61,000, up 3 percent from FY 1978. The accompanying chart gives an overview of appellate actions for the past two fiscal years.

Also reflecting the litigious nature of our society and the added emphasis on due process considerations, more and more appellants are asking for formal hearings before the Board. In 1979 the BVA held over 1,000 such hearings in Washington and nearly 500 in field offices before traveling sections. Waiting time on the hearing docket was about 6 months.

At year's end there were 36,200 appeals pending in field offices; 11,400 were in final stages of processing. Both figures are new highs, the latter representing a marked increase from the 7,200 of 3 years ago. Coupled with 11,600 cases on the Board's docket, the number of appeals in all stages of development was a record 47,800.

In recent years the number of appeals, the trend toward more multiple-issue cases, and the large portion of appellants seeking formal hearings have combined to increase the Board's response time to appeals. Average response time at the BVA has risen from 74 days in 1976, to 127 days in 1979.

Appellants continued to rely heavily on veterans' service organizations for representation, 82 percent selecting one of the accredited organizations, and 2 percent using attorneys or agents. The rest chose to handle their appeals without representation, an option which declined steadily during the past decade from about 25 percent to less than 16 percent.

The BVA had an average employment level of 334 during the year. Headed by a chairman and a vice chairman, the Board had 16 sections with 33 legal and 15 medical members supported by 4 medical advisors and 106 staff attorneys. Other professional support available within the VA included advisory medical opinions from the Chief Medical Director and legal opinions from the General Counsel. In addition, during FY 1979 the Board requested 225 opinions from independent medical experts who were not VA employees.

In compliance with the Freedom of Information Act the BVA published its first index of decisions in April 1979. By the end of the fiscal year this index covered the four quarters from July 1, 1977 through June 30, 1978. Developed as part of the Appellate Index and Retrieval System, these indexes appear on microfiche, and the decisions, stripped of personal identifiers, are stored on microfilm. Appellants and others interested in decisions of the Board are able to locate specific cases, and can request copies of the desired decisions.

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Estimated Number, State, Period of Service—September 30, 1979

(In Thousands)

State	Total Veterans	War Veterans: Total [1]	Vietnam Era: Total [2]	Vietnam Era: No Service in Korean Conflict	Korean Conflict: Total [2,3]	Korean Conflict: No Service in World War II	World War II [1]	World War I [1]	Post Vietnam Era[4]	Service Between Korean Conflict and Vietnam Era Only
Total	30,072	26,310	8,910	8,363	5,866	4,679	12,674	594	703	3,059
State Total	29,829	26,109	8,809	8,265	5,810	4,631	12,626	587	694	3,026
Alabama	422	369	125	116	91	74	171	8	9	44
Alaska	40	34	15	15	8	6	13	(1)	1	5
Arizona	329	289	102	96	66	49	137	7	8	32
Arkansas	270	240	79	74	48	37	122	7	5	25
California	3,343	2,936	985	924	734	526	1,430	56	79	328
Colorado	375	334	129	122	73	55	141	6	10	41
Connecticut	463	406	131	122	96	80	196	6	11	46
Delaware	79	66	25	23	17	9	33	1	2	11
District of Columbia	101	89	22	20	20	22	45	2	2	10
Florida	1,318	1,177	362	326	269	184	620	41	25	116
Georgia	637	551	215	203	134	100	231	9	16	70
Hawaii	96	79	33	31	20	17	30	1	2	13
Idaho	106	91	33	31	18	15	43	2	3	11
Illinois	1,546	1,363	438	402	300	287	654	30	35	157
Indiana	720	631	230	217	132	113	287	14	20	78
Iowa	346	305	113	107	63	54	164	10	6	41
Kansas	312	274	93	88	53	42	130	8	7	31
Kentucky	414	363	122	115	70	63	170	9	8	43
Louisiana	453	399	130	122	94	70	180	9	10	45
Maine	153	136	44	42	25	21	67	4	3	16
Maryland	620	540	195	183	137	106	253	9	16	64
Massachusetts	871	764	255	240	171	130	366	10	20	87
Michigan	1,183	1,030	367	347	216	180	472	21	30	130
Minnesota	560	482	189	180	89	74	216	13	16	60
Mississippi	244	216	65	61	40	30	110	6	4	24
Missouri	709	632	207	194	130	112	300	16	16	71
Montana	80	66	30	29	16	13	42	2	2	12
Nebraska	202	170	63	60	36	29	81	5	6	23
Nevada	95	83	29	27	19	14	41	1	3	9
New Hampshire	120	100	38	36	22	17	52	2	3	15
New Jersey	1,107	973	287	276	225	180	491	20	22	111
New Mexico	137	116	42	39	27	21	57	2	3	16
New York	2,477	2,187	610	567	505	436	1,144	60	51	239
North Carolina	632	561	200	189	116	96	246	11	13	60
North Dakota	61	53	17	16	8	7	27	2	1	6
Ohio	1,483	1,290	447	420	301	230	632	27	30	155
Oklahoma	410	360	127	120	77	56	172	9	9	41
Oregon	385	337	119	113	66	48	157	9	10	38
Pennsylvania	1,747	1,536	480	457	315	269	795	34	40	171
Rhode Island	154	133	42	40	29	22	60	3	4	17
South Carolina	335	293	114	109	66	54	134	5	8	35
South Dakota	76	65	18	17	13	11	34	3	1	9
Tennessee	561	472	166	157	106	90	215	10	13	56
Texas	1,689	1,452	514	483	316	242	690	23	30	169
Utah	150	128	57	54	35	[illegible]	53	3	6	17
Vermont	64	56	21	20	9	8	25	1	2	6
Virginia	661	577	213	199	140	97	271	10	14	70
Washington	612	530	201	190	118	81	260	11	16	64
West Virginia	235	208	63	59	41	35	108	6	5	22
Wisconsin	590	511	186	175	80	64	237	10	10	63
Wyoming	45	39	14	13	7	5	20	1	1	6
Outside U.S. – Total[5]	243	201	101	98	56	48	48	7	9	33

NOTE: These estimates have been developed from "bench mark" veteran population statistics for the states as of June 30, 1970, based on 1970 Census of Population data on veterans' place of residence, extended to September 30, 1979, on the basis of (1) 1965-1970 veteran interstate migration statistics from the 1970 Census, (2) Bureau of the Census provisional estimates of 1970-1971 net civilian migration of the states, "Current Population Reports", Series P-25, No. 468, October 5, 1971 and (3) mobility of the United States Population 1975-1976, "Current Population Reports", Series P-20, No. 305, January 1977. They are independent of, and therefore not directly comparable with, estimates for June 30, 1970 through June 30, 1974, previously published. Excluded are an estimated 157 (thousand) who served only between World War I and World War II, and 242 (thousand) who served only between World War II and the Korean Conflict.

See footnotes at end of Table 3.

Estimated Number, Regional Office, Period of Service —September 30, 1979

(In Thousands)

Regional Office		Total Veterans	War Veterans							Post-Vietnam Era[4]	Service Between Korean Conflict and Vietnam Era Only
			Total[1]	Vietnam Era		Korean Conflict		World War II[3]	World War I[3]		
				Total[2]	No Service in Korean Conflict	Total[2,3]	No Service in World War II				
Total		30,072	26,310	8,910	8,362	5,980	4,670	12,674	590	702	3,050
Alabama	Montgomery	402	360	125	110	91	74	171	8	8	34
Alaska	Juneau	40	34	16	15	8	6	13	(¹)	1	5
Arizona	Phoenix	330	289	102	98	66	46	137	7	9	32
Arkansas	Little Rock	274	244	80	75	49	38	124	7	5	25
California	Los Angeles	1,734	1,515	488	455	373	280	743	37	40	180
	San Diego	311	273	106	98	77	61	107	7	8	30
	San Francisco	1,302	1,143	389	352	283	204	505	83	31	128
Colorado	Denver	375	304	130	122	73	55	121	6	10	61
Connecticut	Hartford	483	406	131	122	99	80	195	9	11	66
Delaware	Wilmington	79	66	25	23	12	9	33	1	2	11
District of Columbia	Washington	449	391	143	132	108	73	181	5	11	47
Florida	St. Petersburg	1,310	1,177	352	326	280	184	626	41	25	110
Georgia	Atlanta	637	551	215	203	134	108	231	9	16	70
Hawaii	Honolulu	94	79	33	31	20	17	30	1	2	13
Idaho	Boise	105	91	33	31	19	15	43	2	3	11
Illinois	Chicago	1,546	1,353	430	402	308	267	654	30	35	157
Indiana	Indianapolis	720	631	230	217	132	113	287	14	20	70
Iowa	Des Moines	375	325	113	107	63	54	154	10	9	41
Kansas	Wichita	312	274	93	88	53	42	136	8	7	31
Kentucky	Louisville	414	363	122	115	70	63	176	9	8	43
Louisiana	New Orleans	453	398	130	122	94	70	198	8	10	45
Maine	Togus	153	134	44	42	28	21	67	4	3	16
Maryland	Baltimore	419	367	125	116	80	71	173	7	10	42
Massachusetts	Boston	780	691	232	216	165	126	330	19	10	79
Michigan	Detroit	1,180	1,028	387	367	216	168	472	21	32	120
Minnesota	St. Paul	535	463	179	170	83	69	212	12	15	57
Mississippi	Jackson	264	216	85	81	48	30	110	8	4	30
Missouri	St. Louis	709	622	207	194	126	112	300	16	16	71
Montana	Ft. Harrison	100	86	30	28	16	13	42	3	2	12
Nebraska	Lincoln	202	175	63	60	34	29	81	5	5	22
Nevada	Reno	101	88	30	28	20	10	49	1	3	10
New Hampshire	Manchester	126	108	38	36	22	17	53	2	3	15
New Jersey	Newark	1,107	973	297	276	205	186	481	30	23	111
New Mexico	Albuquerque	137	119	42	39	27	21	57	2	3	15
New York	Buffalo	648	572	171	160	132	113	287	12	14	62
	New York	1,820	1,676	430	407	373	323	907	39	37	107
North Carolina	Winston-Salem	632	541	200	190	116	96	245	11	13	80
North Dakota	Fargo	94	81	27	26	13	12	40	3	2	11
Ohio	Cleveland	1,483	1,290	447	420	281	200	632	37	38	155
Oklahoma	Muskogee	410	360	127	120	77	59	172	9	9	41
Oregon	Portland	365	327	119	113	66	49	160	5	10	28
Pennsylvania	Philadelphia	1,110	974	316	296	203	158	489	31	26	110
	Pittsburgh	664	586	177	165	117	98	309	14	15	63
Puerto Rico	San Juan	170	141	48	47	55	48	43	3	6	23
Rhode Island	Providence	237	206	66	62	45	35	104	5	6	25
South Carolina	Columbia	336	292	114	105	66	54	128	5	8	36
South Dakota	Sioux Falls	75	65	18	17	12	11	34	3	1	9
Tennessee	Nashville	541	472	160	157	106	90	215	10	13	56
Texas	Houston	730	640	230	219	143	100	310	10	17	76
	Waco	917	812	304	287	172	132	383	10	22	83
Utah	Salt Lake City	150	129	57	54	25	18	53	3	4	17
Vermont	White River Jct.	64	54	21	20	9	6	28	1	2	8
Virginia	Roanoke	521	455	162	152	107	70	215	9	11	55
Washington	Seattle	612	532	201	190	110	81	250	11	16	64
West Virginia	Huntington	198	174	56	53	38	31	85	5	4	20
Wisconsin	Milwaukee	589	511	185	175	99	84	237	15	16	62
Wyoming	Cheyenne	45	39	14	13	7	5	20	1	1	5
Philippines	Manila	9	5	(¹)	(¹)	(¹)	(¹)	4	1	1	3
Outside Regional Office Areas		64	55	53	51	1	(¹)	1	3	2	7

NOTE: For all regional offices whose jurisdiction includes only part of a state or extends into another state, the estimates of veterans are computed by applying the most recent veteran population ratio factors for the counties or urban places involved. These factors were developed from county veteran population estimates as of June 30, 1970 based on the U.S. Census of Population 1970. Refer to general note below Table 1.

See footnotes at end of Table 3.

Estimated Age, Period of Service—September 30, 1979

(In Thousands)

Age	Total Veterans	War Veterans								Post-Vietnam Era[4]	Service Between Korean Conflict and Vietnam Era Only
		Total[1]	Vietnam Era		Korean Conflict		World War II[3]	World War I[a]			
			Total[2]	No Service in Korean Conflict	Total[2,3]	No Service in World War II					
All Ages	30,070[5]	26,390[5]	8,970	8,360	5,986	4,670	12,874	596		550	3,060
Under 20 yrs	67									67	
20-24 yrs	1,084	540	540	540						544	
25-29 yrs	2,085	1,990	1,990	1,990						95	
30-34 yrs	3,838	3,774	3,774	3,774						14	50
35-39 yrs	2,794	1,705	1,705	1,705						3	1,086
40-44 yrs	2,052	681	365	360	321	321	(7)			(7)	1,371
45-49 yrs	3,353	2,986	330	35	2,872	2,870	81				367
50-54 yrs	6,074	6,053	160	10	1,580	1,100	4,943				21
55-59 yrs	4,633	4,629	60	4	463	86	4,539				4
60-64 yrs	2,995	2,995	45	1	226	46	2,948				
65-69 yrs	1,362	1,362	14	(7)	84	5	1,357				
70-74 yrs	633	633	2	(7)	26	(7)	633				
75-79 yrs	178	178	(7)		9	(7)	150	28			
80-84 yrs	351	351			0		63	288			
85 yrs & Over	223	223			(7)		8	215			
Average Age[6]	47.5	48.9	32.9	31.8	48.7	47.5	59.1	84.3		23.3	40.3

NOTE: Includes an estimated 117 (thousand) who served only between World War I and World War II, all of whom are 63 years of age or older and 282 (thousand) who served only between World War II and the Korean Conflict who are 45-59 years of age.

[1] Veterans who served in both World War II and the Korean Conflict, and in both the Korean Conflict and the Vietnam era are counted once.

[2] Includes 347 (thousand) who served in both the Korean Conflict and the Vietnam era.

[3] Includes 1,287 (thousand) who served in both World War II and the Korean Conflict.

[4] Service only after May 7, 1975.

[5] Includes Commonwealth of Puerto Rico, U.S. possessions and military areas, and foreign countries.

[6] Computed from data by single years of age.

[7] Less than 0.5 (thousand).

[a] There are also 200 living Spanish-American War veterans—average age 101.2 years.

TABLE 4

Hospital Care and Extended Care: Average Daily Census[1]
Fiscal Years 1970–1979

Fiscal Years	Total	Hospitals				Domiciliaries			Nursing Homes			
		Total	VA Medical Centers–Hospital Care Component[3]	Non-VA	State	Total	VA Medical Centers–Domiciliary Care Component[2]	State	Total	VA Medical Centers–Nursing Home Care Component	Community	State
1979...	106,816	71,983	69,821	1,182	980	13,744	8,448	5,296	21,089	7,760	8,126	5,203
1978...	109,769	75,390	73,008	1,378	1,004	13,957	8,721	5,236	20,422	7,480	7,997	4,945
1977...	111,164	77,671	75,285	1,344	1,042	14,214	8,933	5,281	19,279	7,166	7,507	4,606
1976...	113,055	80,519	78,264	1,233	1,022	14,652	9,090	5,562	17,884	6,993	6,646	4,245
1975...	114,384	82,253	79,973	1,267	1,013	15,030	9,181	5,849	17,101	6,739	6,239	4,123
1974...	114,426	83,534	81,453	1,053	1,028	15,584	9,723	5,861	15,308	6,418	4,885	4,005
1973...	115,170	84,556	82,479	1,031	1,046	16,286	10,261	6,025	14,328	6,094	4,572	3,662
1972...	113,767	83,105	80,871	1,154	1,080	17,957	11,989	5,968	12,705	5,440	3,930	3,335
1971...	115,758	86,319	84,002	1,251	1,066	18,565	12,685	5,880	10,874	4,599	3,377	2,898
1970...	116,580	87,460	85,547	1,495	418	19,347	12,665	6,682	9,773	3,700	3,641	2,432

[1] *Fiscal year averages based on total patient bed days during year divided by the number of days in year.*

[2] *Includes restoration center program data for fiscal years 1970 through 1972.*

[3] *Beginning with FY 1973, patients coming to VA hospitals for chronic dialysis are considered to be inpatients; there was an average daily patient census of 61[illegible] with one day duration of stay during FY 1979.*

TABLE 5

Hospital Care and Extended Care: Admissions
Fiscal Years 1970–1979

Fiscal Years	Total	Hospitals				Domiciliaries			Nursing Homes			
		Total	VA Medical Centers–Hospital Care Component[1] [3]	Non-VA	State	Total	VA Medical Centers–Domiciliary Care Component[2]	State	Total	VA Medical Centers–Nursing Home Care Component	Community	State
1979...	1,236,987	1,196,169	1,162,566	28,403	5,200	12,278	6,920	5,358	28,540	4,428	19,925	4,187
1978...	1,233,818	1,193,613	1,157,787	30,369	5,457	12,382	7,230	5,152	27,823	4,157	19,314	4,352
1977...	1,211,029	1,170,563	1,133,380	31,449	5,734	12,998	7,755	5,243	27,468	3,966	19,340	4,162
1976...	1,175,149	1,136,286	1,102,271	28,239	5,776	14,134	8,169	5,965	24,729	4,023	16,553	4,153
1975...	1,107,808	1,069,757	1,036,101	27,710	5,946	14,478	7,831	6,647	23,573	3,767	16,056	3,750
1974...	1,028,502	991,473	964,466	21,091	5,916	15,558	8,522	7,036	21,471	3,834	13,598	4,039
1973...	968,203	932,481	905,545	20,816	6,120	17,459	10,365	7,094	18,263	4,002	10,774	3,487
1972...	829,306	793,538	765,786	21,578	6,174	18,712	12,103	6,609	17,056	3,786	10,135	3,135
1971...	783,956	750,546	723,907	20,952	5,687	18,599	13,627	4,972	14,811	3,549	8,407	2,855
1970...	744,619	711,289	687,037	20,524	3,728	19,838	13,629	6,209	13,492	2,018	9,388	2,086

[1] *Interhospital transfer data are excluded.*

[2] *Includes restoration center program data for fiscal years 1970-1972.*

[3] *Beginning with FY 1973, patients coming to VA hospitals for chronic dialysis are considered to be inpatients, there were 224,590 admissions for one day duration of stay during FY 1979.*

TABLE 6

VA Medical Centers: Average Operating Beds[1]
Fiscal Years 1970–1979

Fiscal Years	All VA Facilities	Hospital Care Component				Domiciliary Care Component[2]	Nursing Home Care Component
		Total	Bed Section				
			Medical	Surgical	Psychiatric		
1979	105,459	87,713	42,772	18,542	26,402	9,389	8,357
1978	108,891	91,215	44,372	19,175	27,668	9,792	7,884
1977	109,879	92,370	44,587	19,610	28,173	9,936	7,573
1976	111,574	94,075	44,943	19,854	29,278	10,101	7,398
1975	112,143	94,801	44,893	19,725	30,183	10,310	7,032
1974	113,714	96,106	45,331	19,597	31,178	10,839	6,769
1973	115,369	97,689	45,261	19,640	32,788	11,172	6,508
1972	115,268	96,352	40,003	19,212	37,137	13,097	5,819
1971	117,640	98,956	35,733	19,366	43,857	13,632	5,052
1970	120,614	102,633	36,166	19,386	47,082	13,979	4,002

[1] *Fiscal year averages are based on the number of operating beds at the end of each month for 13 consecutive months, beginning with June of the prior year and ending with June of the indicated fiscal year. Beginning with FY 1977 averages are based on the number of operating beds at the end of each month for 13 consecutive months, beginning with September of the prior year and ending with September of the indicated fiscal year.*

[2] *Includes restoration center program data for fiscal years 1970-1972.*

TABLE 7

Hospital Care and Extended Care: Patients Remaining (On Rolls) At End of Period¹—Fiscal Years 1970–1979

Fiscal Years	Total	Hospitals								Domiciliaries			Nursing Homes			
		Total	VA Medical Centers—Hospital Care Component			Non VA			State	Total	VA Medical Centers—Domiciliary Care Component ⁴	State	Total	VA Medical Centers Nursing Home Care Component	Community	State
			Total	Bed Occupants	ABO ²	Total	Bed Occupants	ABO ³								
1979	106,349	69,828	67,897	66,914	983	945	923	22	986	14,245	9,061	5,184	22,276	8,092	8,836	5,348
1978	108,529	72,283	70,134	69,062	1,072	1,164	1,162	2	985	14,858	9,595	5,263	21,388	7,893	8,336	5,159
1977	111,267	75,271	73,116	72,010	1,106	1,138	1,123	15	1,017	15,282	9,902	5,380	20,714	7,603	8,310	4,801
1976	112,114	77,750	75,786	74,413	1,373	957	942	15	1,007	15,317	10,120	5,197	19,047	7,419	7,196	4,432
1975	113,422	79,499	77,432	76,007	1,425	1,031	1,008	23	1,036	15,882	10,226	5,656	18,041	7,075	6,869	4,097
1974	114,174	80,526	78,640	76,847	1,793	852	811	41	1,034	16,415	10,653	5,762	17,233	6,828	6,287	4,118
1973	113,488	81,146	79,336	77,356	1,980	793	762	31	1,017	17,322	11,373	5,949	15,020	6,526	4,687	3,807
1972	113,492	81,489	79,406	77,344	2,062	1,053	820	233	1,030	18,107	12,235	5,872	13,896	5,627	4,740	3,529
1971	114,179	82,207	79,985	78,453	1,532	1,146	952	194	1,076	20,041	14,310	5,731	11,931	4,935	3,849	3,147
1970	126,800	96,040	93,805	81,976	11,829	1,202	1,034	168	1,033	20,326	14,364	5,962	10,434	3,907	3,936	2,591

[1] Patients remaining (on rolls) on June 30 of each fiscal year 1970 through 1976 and September 30 of fiscal years 1977-1979.
[2] Denotes absent bed occupants, i.e., patients on authorized leave of absence.
[3] Denotes absent bed occupants, i.e., patients on authorized leave of absence.
[4] Includes restoration center program data for fiscal years 1970-1972.

TABLE 8

HEALTH CARE

Hospital Care and Extended Care: Total Discharges¹—Fiscal Years 1970–1979

Fiscal Years	Total	Hospitals				Domiciliaries			Nursing Homes			
		Total	VA Medical Centers—Hospital Care Component ² ³	Non-VA	State	Total	VA Medical Centers—Domiciliary Care Component ³	State	Total	VA Medical Centers—Nursing Home Care Component	Community	State
1979	1,235,811	1,195,884	1,162,355⁴	28,323	5,206	12,832	7,480	5,352	27,095	4,190	18,971	3,934
1978	1,233,634	1,194,367	1,158,621⁴	30,253	5,493	12,914	7,680	5,234	26,353	3,778	18,660	3,915
1977	1,211,506	1,173,740	1,136,647⁴	31,378	5,715	13,173	8,103	5,070	24,593	3,714	17,048	3,831
1976	1,174,973	1,137,231	1,103,108⁴	28,316	5,807	14,635	8,288	6,347	23,107	3,522	15,802	3,783
1975	1,106,685	1,069,945	1,036,441⁴	27,573	5,931	14,668	8,262	6,406	22,072	3,457	14,880	3,735
1974	1,026,576	991,589	964,653⁴	21,047	5,889	15,969	9,289	6,680	19,018	3,496	11,850	3,672
1973	968,469	933,237	906,015⁴	21,084	6,138	17,471	10,721	6,750	17,761	3,009	11,592	3,160
1972	830,097	794,785	766,892	21,682	6,211	20,215	14,201	6,014	15,097	2,959	10,049	2,089
1971	798,163	765,268	738,594	21,022	5,652	19,221	13,823	5,398	13,674	2,453	8,965	2,266
1970	752,249	717,022	693,496	20,840	2,686	20,917	13,949	6,968	14,310	1,937	10,639	1,734

[1] Includes deaths.
[2] Interhospital transfer data are excluded.
[3] Includes restoration center program data for fiscal years 1970-1972.
[4] Beginning with FY 1973, patients coming to VA hospitals for chronic dialysis are considered to be inpatients; there were 44,000 discharges with one day duration of stay during the transition quarter and 224,590 during FY 1979.

TABLE 9

HEALTH CARE

Hospital Care and Extended Care: Patients Treated¹—Fiscal Years 1970–1979

Fiscal Years	Total	Hospitals				Domiciliaries			Nursing Homes			
		Total	VA Medical Centers—Hospital Care Component ² ³	Non VA	State	Total	VA Medical Centers—Domiciliary Care Component ²	State	Total	VA Medical Centers—Nursing Home Care Component	Community	State
1979	1,342,161	1,265,712	1,230,252	29,268	6,192	27,077	16,541	10,536	49,372	12,283	27,807	9,282
1978	1,342,164	1,266,651	1,228,755	31,418	6,478	27,772	17,275	10,497	47,741	11,671	26,996	9,074
1977	1,322,773	1,240,011	1,200,763	32,516	6,732	26,456	16,056	10,400	46,307	11,317	25,358	8,632
T.Q.⁴	414,004	370,746	359,864	8,537	2,345	18,950	12,451	6,499	24,308	8,364	10,549	5,395
1976	1,287,087	1,214,981	1,179,894	29,273	5,814	29,952	18,408	11,544	42,154	10,941	22,998	8,215
1975	1,220,107	1,149,444	1,113,873	28,604	6,967	30,550	18,468	12,082	40,113	10,532	21,749	7,832
1974	1,140,750	1,072,125	1,043,293	21,899	6,933	32,374	19,922	12,452	36,251	10,324	18,137	7,790
1973	1,081,985	1,014,383	985,351	21,877	7,155	34,793	22,094	12,699	32,709	9,535	16,287	6,887
1972	944,189	876,274	846,298	22,735	7,241	38,322	26,436	11,886	29,593	8,586	14,789	6,218
1971	912,342	847,475	818,579	22,168	6,728	39,262	28,133	11,129	25,605	7,389	12,803	5,413
1970	879,049	813,062	787,301	22,042	3,719	41,243	28,313	12,930	24,744	5,844	14,575	4,325

[1] Fiscal year data based on number of discharges and deaths during year plus number of patients on the rolls at the end of the year. Transition quarter data based on the number of discharges and deaths during July, August and September 1976, plus the number on the rolls on September 30, 1976.
[2] Includes restoration center program data.
[3] Beginning with FY 1973, patients coming to VA hospitals for chronic dialysis are to be considered inpatients; there were 44,000 patients treated with one day duration of stay during the transition quarter and 224,590 during FY 1979.
[4] Transition Quarter (July, August and September 1976).

Inpatient and Ambulatory Care: Program Summary—Fiscal Year 1979

Location and Type of VA Facility[1]	Inpatient Care — Patients Treated								Ambulatory Care				
	Hospitals			Nursing Homes			Domiciliaries		Medical Visits		Dental Care		
											VA Staff		Fee Basis
	VA Medical Centers—Hospital Care Component	Non-VA[2,3]	State Home[2,4]	VA Medical Centers—Nursing Home Care Component	Community[2,3]	State Home[2,4]	VA Medical Centers—Domiciliary Care Component	State Home[2,4]	VA Staff	Fee Basis[2,5]	Examinations	Treatment Cases Completed	Net Cases Authorized[2,6]
All facilities — Total	1,230,252	29,280	6,182	12,293	27,807	9,282	16,541	10,536	15,053,332	2,209,078	128,195	134,780	89,848
Alabama:													
Birmingham	13,115	....	....	....	228	....	....	....	106,830	....	2,764	3,012	....
Montgomery	2,936	277	....	....	40	....	....	....	38,907	38,508	457	559	1,361
Montgomery	2,936	277	....	....	49	....	....	....	32,912	38,508	457	559	....
Mobile (S)	....	....	....	....	....	....	....	....	5,995	....	....	....	....
Tuscaloosa	4,780	3	....	154	165	....	....	....	47,587	....	515	669	....
Tuskegee	7,140	....	....	142	40	....	....	....	40,629	....	506	420	....
Alaska: Anchorage (R)	....	3,380	....	....	30	....	....	....	226	22,235	....	....	316
Arizona:													
Phoenix	8,810	229	....	170	438	....	....	....	118,005	18,615	944	881	665
Prescott	3,714	....	....	....	17	....	440	....	26,500	....	205	170	....
Tucson	9,902	81	....	66	231	....	....	....	113,198	....	298	309	....
Arkansas:													
Fayetteville	4,958	....	....	....	57	....	....	....	21,787	....	130	313	....
Little Rock	18,393	403	....	252	292	....	....	....	167,235	39,290	720	1,025	1,939
Little Rock	18,393	403	....	252	292	....	....	....	93,822	39,290	390	675	1,939
No. Little Rock	....	....	....	....	....	....	....	....	73,413	....	330	350	....
California:													
Fresno	5,066	....	....	....	121	....	....	....	63,940	....	331	219	....
Livermore	2,898	....	....	....	75	....	....	....	33,770	....	220	404	....
Loma Linda	6,884	43	....	226	139	....	....	....	119,298	....	1,600	1,274	....
Long Beach	20,984	....	....	353	663	....	....	....	300,588	....	1,174	1,561	20
Los Angeles — Brentwood	3,932	....	....	....	166	....	....	....	170,049	....	57	267	....
Los Angeles — Wadsworth	16,254	....	....	....	432	....	634	....	193,071	....	4,395	4,180	....
Los Angeles (I)	....	680	....	....	....	....	....	....	169,833	84,533	1,523	1,754	4,687
Martinez	7,487	3	....	....	111	....	....	....	195,619	....	1,323	952	....
Martinez	7,487	3	....	....	111	....	....	....	87,942	....	403	233	....
Oakland (S)	....	....	....	....	....	....	....	....	28,183	....	....	....	....
Sacramento (S)	....	....	....	....	....	....	....	....	39,494	....	920	719	....
Palo Alto	13,127	1	....	148	231	....	....	....	179,546	....	1,014	993	....
Palo Alto Div	13,127	1	....	148	231	....	....	....	96,560	....	910	863	....
Menlo Park Div	....	....	....	....	....	....	....	....	79,986	....	104	130	....
San Diego	15,400	134	....	186	112	....	....	....	204,554	10,311	2,210	1,669	1,889
San Diego (La Jolla Village Dr.)	15,400	134	....	186	112	....	....	....	146,182	10,311	2,210	1,669	1,889
San Diego (Camino Del Rio No.) (S)	....	....	....	....	....	....	....	....	58,372	....	....	....	....
San Francisco	10,094	675	1,454	....	180	785	....	1,677	183,797	154,280	1,916	1,738	7,927
Sepulveda	10,926	....	....	223	178	....	....	....	196,306	....	1,155	1,320	....
Colorado:													
Denver	12,106	299	....	....	180	204	....	106	129,444	21,759	709	958	2,038
Ft. Lyon	1,280	9	....	50	46	....	....	....	20,208	....	38	52	....
Grand Junction	2,409	....	....	62	88	....	....	....	15,756	....	129	129	....

Connecticut:													
Newington	3,046	136	969	....	182	....	....	942	88,003	31,389	637	573	293
West Haven	11,297	....	....	106	114	....	....	....	119,190	....	1,247	1,496	....
Delaware: Wilmington	4,422	8	....	83	242	336	....	84	41,334	3,580	935	1,714	119
District of Columbia:													
Washington	17,104	75	....	....	223	....	....	719	169,802	2,406	2,026	878	1,292
Florida:													
Bay Pines	7,507	3,046	....	195	502	....	492	....	147,970	187,676	1,534	1,866	2,867
Bay Pines	7,507	3,046	....	195	502	....	492	....	78,730	187,676	613	770	....
St. Petersburg (S)	....	....	....	....	....	....	....	....	69,240	....	911	796	2,867
Gainesville	11,946	17	....	....	245	....	....	....	142,330	....	1,317	962	....
Gainesville	11,946	17	....	....	245	....	....	....	103,134	....	569	305	....
Jacksonville (S)	....	....	....	....	....	....	....	....	39,196	....	748	657	....
Lake City	7,343	6	....	57	62	....	....	....	22,987	....	114	314	....
Miami	18,070	386	....	200	386	....	....	....	280,839	....	2,127	2,761	....
Miami	18,070	386	....	200	386	....	....	....	235,035	....	1,438	1,856	....
Riviera Beach (S)	....	....	....	....	....	....	....	....	45,804	....	689	905	....
Tampa	21,741	39	....	....	505	....	....	....	190,130	....	1,042	1,921	....
Tampa	21,741	39	....	....	505	....	....	....	140,167	....	550	1,195	....
Orlando (S)	....	....	....	....	....	....	....	....	49,963	....	492	726	....
Georgia:													
Atlanta	12,790	418	....	....	380	....	....	....	163,807	48,483	1,443	2,451	3,196
Augusta	11,204	16	....	52	296	342	....	....	79,145	....	806	685	....
Forest Hills Div	11,204	16	....	52	296	342	....	....	56,551	....	708	616	....
Lenwood Div	....	....	....	....	....	....	....	....	22,594	....	118	69	....
Dublin	5,348	....	....	113	140	155	627	561	22,192	....	114	258	....
Hawaii: Honolulu (R)	....	1,736	....	....	37	....	....	....	43,308	6,291	1,562	364	435
Idaho: Boise	3,077	251	....	....	172	....	....	216	44,984	16,084	500	494	987
Illinois:													
Chicago (Lake Side)	12,391	5	....	....	318	....	....	....	109,264	....	575	744	....
Chicago (West Side)	8,174	342	....	....	274	....	....	....	193,025	44,787	2,080	1,872	2,177
Danville	4,830	....	....	174	184	....	....	....	38,542	....	414	1,145	....
Hines	23,880	....	....	....	643	....	....	....	190,898	....	374	1,214	....
Marion	3,381	13	....	....	183	....	....	....	43,449	....	174	276	....
Marion	3,381	13	....	....	183	....	....	....	19,243	....	174	276	....
Evansville (S)	....	....	....	....	....	....	....	....	24,206	....	....	....	....
North Chicago	8,158	....	....	232	226	....	....	....	91,115	....	221	265	....
Indiana:													
Ft. Wayne	2,813	....	....	70	109	....	....	....	12,239	....	192	147	....
Indianapolis	13,326	259	....	80	194	227	....	118	93,913	37,363	1,467	990	684
Cold Spring Road Div	13,326	259	....	80	194	227	....	118	14,913	37,363	229	6	....
West 10th Street Div	....	....	....	....	....	....	....	....	79,000	....	1,238	984	684
Marion	3,229	....	....	101	123	....	....	....	26,900	....	194	132	....
Iowa:													
Des Moines	6,556	58	281	....	202	406	....	160	68,565	27,030	789	920	907
Iowa City	11,602	186	437	....	302	787	....	215	55,813	....	899	1,277	....
Knoxville	2,101	....	....	281	155	....	....	....	28,586	....	270	283	....
Kansas:													
Leavenworth	4,829	....	....	65	104	....	1,874	....	30,182	....	369	487	....
Topeka	5,192	....	....	90	144	....	....	....	80,318	....	216	254	....
Wichita	4,325	56	....	....	56	79	....	78	37,206	14,862	630	797	428
Kentucky:													
Lexington	12,087	....	....	122	209	....	....	....	101,280	....	463	727	....
Leestown Div	12,087	....	....	122	209	....	....	....	37,153	....	162	333	....
Cooper Dr. Div	12,087	....	....	....	....	....	....	....	64,127	....	301	394	....
Louisville	8,004	121	....	....	165	....	....	....	79,850	16,078	963	1,220	465
Louisiana:													
Alexandria	5,[illegible]	2	....	112	77	....	....	....	32,409	....	275	172	....
New Orleans	11,656	81	....	....	215	....	....	171	182,316	38,261	648	825	773
Shreveport	9,1[illegible]	91	....	....	201	....	....	....	68,382	15,067	806	1,180	543
Maine: Togus	7,454	150	....	79	130	....	....	....	46,052	24,553	484	441	544

See footnotes at end of table.

Inpatients and Ambulatory Care: Program Summary–Fiscal Year 1979–Continued

Location and Type of VA Facility[1]	Inpatient Care–Patients Treated								Ambulatory Care				
	Hospitals			Nursing Homes			Domiciliaries		Medical Visits		Dental Care		
											VA Staff		Fee Basis
	VA Medical Centers–Hospital Care Component	Non-VA[2,3]	State Home[2,4]	VA Medical Centers–Nursing Home Care Component	Community[2,3]	State Home[2,4]	VA Medical Centers–Domiciliary Care Component	State Home[2,4]	VA Staff	Fee Basis[2,5]	Examinations	Treatment Cases Completed	Net Cases Authorized[2,6]
Maryland:													
Baltimore	6,459	79	....	....	112	....	....	....	147,364	8,472	617	791	....
Baltimore (Loch Raven Road)	6,459	79	....	....	112	....	....	....	73,839	8,472	246	464	....
Baltimore (Federal Building) (S)	....	....	....	....	....	....	....	....	73,525	....	371	327	449
Ft. Howard	2,036	....	....	53	68	....	....	....	20,131	....	118	104	....
Perry Point	2,081	....	....	113	50	....	....	....	37,908	....	99	34	....
Massachusetts:													
Bedford	3,332	6	....	186	141	....	....	....	107,166	....	596	566	....
Boston	14,600	12	....	....	258	....	....	....	169,985	....	1,088	398	....
Boston (So. Hunting Ave.)	14,600	12	....	....	258	....	....	....	140,409	....	1,088	398	....
Lowell (S)	....	....	....	....	....	....	....	....	29,576	....	....	....	....
Boston (Cort Street) (I)	....	275	2,038	....	....	269	....	578	186,607	42,404	1,278	1,321	466
Brockton	3,869	....	....	131	100	....	....	....	99,625	....	1,067	1,037	....
Northampton	2,802	27	258	59	87	402	....	81	68,811	....	277	287	....
Northampton	2,802	27	258	59	87	402	....	81	52,341	....	277	287	....
Springfield (S)	....	....	....	....	....	....	....	....	16,470	....	....	....	....
West Roxbury	4,496	....	....	....	27	....	....	....	61,908	....	584	803	....
West Roxbury	4,496	....	....	....	27	....	....	....	39,718	....	584	803	....
Worcester (S)	....	....	....	....	....	....	....	....	22,190	....	....	....	....
Michigan:													
Allen Park	12,001	485	....	98	232	....	....	....	177,793	51,178	1,260	638	2,416
Ann Arbor	183,214	....	....	....	181	....	....	....	68,847	....	606	679	....
Ann Arbor	11,632	....	....	....	181	....	....	....	68,847	....	497	596	....
Toledo, OH (OCS)	171,582	....	....	....	....	....	....	....	....	....	109	83	....
Battle Creek	4,290	....	....	230	104	....	....	....	90,907	....	599	908	....
Battle Creek	4,290	....	....	230	104	....	....	....	65,039	....	157	332	....
Grand Rapids (S)	....	....	....	....	....	690	....	259	25,868	....	442	576	....
Iron Mountain	4,013	44	....	52	33	....	....	....	22,390	5,066	70	193	102
Saginaw	3,670	....	....	....	133	....	....	....	25,913	....	162	214	....
Minnesota:													
Minneapolis	20,158	308	....	....	503	139	....	1,080	201,136	43,425	1,312	1,109	4,878
Minneapolis	20,158	308	....	....	503	139	....	1,080	168,035	43,425	1,312	1,109	4,878
St. Paul (S)	....	....	....	....	....	....	....	....	33,101	....	....	....	....
St. Cloud	2,801	1	....	98	117	....	....	....	45,768	....	410	416	....
Mississippi:													
Biloxi	6,861	....	....	42	195	....	820	....	68,473	....	672	716	....
Biloxi Div	6,861	....	....	42	195	....	820	....	36,178	....	567	560	....
Gulfport Div	....	....	....	....	....	....	....	....	32,295	....	105	156	....
Jackson	12,078	113	....	147	116	....	....	....	76,286	29,481	833	946	1,399
Missouri:													
Columbia	7,833	162	....	88	159	....	....	....	59,633	....	113	320	....
Kansas City	12,002	174	....	....	279	....	....	....	89,700	27,390	1,749	1,832	844
Poplar Bluff	3,989	....	....	146	116	....	....	....	33,818	....	399	275	....
St. Louis	14,096	40	....	109	316	199	....	136	214,087	10,599	1,170	702	955
John Cochran Div	14,096	40	....	109	316	199	....	136	171,596	....	1,081	516	955
Jefferson Barracks Div	....	....	....	....	....	....	....	....	42,491	....	89	186	....

Montana:													
Ft. Harrison	3,305	232	......	......	102	72	......	124	12,636	19,598	90	108	794
Miles City	2,141	......	......	40	69	......	......	......	10,296	......	53	91	......
Nebraska:													
Grand Island	2,832	......	......	64	11	626	......	219	14,312	......	115	238	......
Lincoln	3,795	63	......	......	67	......	......	......	33,948	15,071	210	294	......
Omaha	8,657	......	......	......	229	......	......	......	73,349	......	276	711	413
Nevada:													
Las Vegas (I)	......	......	......	......	......	......	......	......	28,590	......	440	452	......
Reno	4,093	241	......	30	66	......	......	......	41,592	6,392	284	294	281
New Hampshire: Manchester	3,798	112	......	341	134	121	......	......	65,883	13,540	507	542	559
New Jersey:													
East Orange	16,240	155	......	121	365	319	......	128	190,137	41,105	2,498	1,924	655
East Orange	16,240	155	......	121	365	319	......	128	127,641	41,105	2,498	1,924	......
Newark (S)	......	......	......	......	......	......	......	......	62,496	......	......	......	......
Lyons	4,014	......	......	124	72	......	......	......	43,234	......	385	265	......
New Mexico: Albuquerque	9,351	69	......	102	204	......	......	......	100,033	19,940	611	694	627
New York:													
Albany	8,646	41	......	111	74	......	......	......	111,451	24,449	1,176	1,689	910
Batavia	2,202	......	......	......	13	......	......	......	75,738	......	90	211	......
Batavia	2,202	......	......	......	13	......	......	......	27,184	......	90	211	......
Rochester (S)	......	......	......	......	......	......	......	......	48,554	......	......	......	......
Bath	1,440	10	......	322	23	......	1,121	......	13,304	759	169	169	7
Bronx	14,632	......	......	......	58	......	......	......	161,006	......	3,193	3,678	......
Brooklyn	18,008	308	......	422	61	......	......	......	187,765	......	1,920	1,699	......
Brooklyn Div	18,008	308	......	422	61	......	......	......	163,430	......	1,450	981	......
St. Albans Div	......	......	......	......	......	......	......	......	24,316	......	470	718	......
Brooklyn (I)	......	17	......	......	......	......	......	......	121,276	4,630	931	853	163
Buffalo	12,848	44	......	61	84	......	......	......	166,837	24,569	1,286	1,605	542
Canandaigua	3,340	......	......	124	4	......	......	......	37,684	......	156	261	......
Castle Point	2,475	......	......	176	14	......	......	......	24,153	......	629	754	......
Montrose	4,500	......	......	161	15	......	......	......	75,041	......	592	515	......
New York	13,852	175	......	......	28	......	......	......	279,845	22,078	1,875	3,815	1,132
New York (First Ave.)	13,852	175	......	......	28	......	......	......	118,784	22,078	1,875	3,815	......
New York (S)	......	......	......	......	......	......	......	......	161,061	......	......	......	......
Northport	10,647	......	......	......	30	......	......	......	209,856	......	1,109	1,109	......
Syracuse	5,706	219	......	63	30	71	......	56	61,834	46,398	621	847	877
North Carolina:													
Asheville	8,384	15	......	102	131	......	......	......	68,607	......	315	436	......
Durham	10,688	......	......	......	178	......	......	......	100,869	......	785	845	......
Fayetteville	5,342	......	......	63	150	......	......	......	52,611	......	381	519	......
Salisbury	5,823	177	......	162	98	......	......	......	78,567	60,040	385	300	......
Salisbury	5,823	177	......	162	98	......	......	......	46,907	60,040	98	158	......
Winston-Salem (S)	......	......	......	......	......	......	......	......	31,660	......	287	142	2,365
North Dakota: Fargo	4,334	406	......	114	80	......	......	137	21,645	16,370	306	439	793
Ohio:													
Chillicothe	4,863	......	......	149	394	......	......	......	44,543	......	237	1,701	......
Cincinnati	10,514	159	......	349	237	......	......	......	116,845	17,534	394	376	963
Cleveland	14,946	327	......	150	423	98	......	986	191,796	55,447	1,351	1,918	......
Wade Park Div	14,946	327	......	150	423	98	......	986	129,925	55,447	1,128	1,651	......
Brecksville	......	......	......	......	......	......	......	......	61,871	......	223	267	1,960
Columbus	......	......	......	......	......	......	......	......	38,186	26,752	......	......	958
Columbus (Clinic Dr.) (I)	......	167	......	......	......	......	......	......	31,309	......	......	......	958
Columbus (S)	......	......	......	......	......	......	......	......	6,877	......	......	......	......
Dayton	7,127	......	......	461	177	......	1,470	......	52,991	......	818	663	......
Oklahoma:													
Muskogee	4,862	72	......	......	212	......	......	......	46,996	23,909	833	586	791
Muskogee	4,862	72	......	......	212	......	......	......	45,995	23,909	833	586	791
Tulsa	......	......	......	......	......	......	......	......	1,001	......	......	......	......
Oklahoma City	14,261	48	573	......	365	1,102	......	783	158,445	......	968	944	......

See footnotes at end of table

Inpatient and Ambulatory Care: Program Summary—Fiscal Year 1979—Continued

Location and Type of VA Facility¹	Inpatient Care—Patients Treated								Ambulatory Care				
	Hospitals			Nursing Homes			Domiciliaries		Medical Visits		Dental Care		
											VA Staff		Fee Basis
	VA Medical Centers—Hospital Care Component	Non-VA	State Home	VA Medical Centers—Nursing Home Care Component	Community	State Home	VA Medical Centers—Domiciliary Care Component	State Home	VA Staff	Fee Basis	Examinations	Treatment Cases Completed	Net Cases Authorized
Oregon:													
Portland	12,446	413			300				101,588	47,595	282	367	1,595
Portland (Marquam Hill)	12,446	413			300				72,385	47,595	282	367	1,595
Portland (SW. Stark St.) (S)									29,203				
Roseburg	3,780	5		119	260				38,340		41	70	
White City (D)		118					2,123		5,461		60	46	
Pennsylvania:													
Altoona	1,835	101		68	67	60		91	19,166	12,210	105	236	631
Butler	2,923	13		137	42				34,190	4,132	342	485	152
Coatesville	4,384	16		69	235				40,384	3,753	112	69	57
Erie	2,866	69		54	59	87		90	27,807	3,013	735	535	211
Lebanon	3,224	97		134	71				53,306	25,636	358	214	587
Lebanon	3,224	97		134	71				42,089	25,636	358	214	
Harrisburg (S)									11,216				
Philadelphia	8,807	482			205				243,382	68,809	2,244	1,001	
Philadelphia (Univ. & Woodland Ave.)	8,807	482			205				151,873	68,809	1,068	916	
Philadelphia (Cherry St.) (S)									91,509		1,176	585	1,867
Pittsburgh (Highland Dr.)	3,086	21			91				56,720	5,858	401	812	118
Pittsburgh	11,985	55		350	207				120,004	13,280	1,563	1,586	77
Pittsburgh (Univ. Dr.) Div	11,985	55		350	207				101,327	13,280	1,434	1,401	77
Aspinwall Div									3,032		129	175	
Pittsburgh (Liberty Ave.) (S)									15,486				
Wheeling, WV (S)									160				
Wilkes-Barre	157,267	153			140				86,204	28,430	1,424	1,366	886
Wilkes-Barre	6,051	153			140				86,204	28,430	1,412	1,361	886
Allentown	151,216										12	5	
Philippines: Manila (R)		1,136							8,031	1,138			9
Puerto Rico:													
San Juan	17,278	4,316			195				248,128	74,130	2,082	1,095	1,703
San Juan	17,278	4,316			195				196,806	74,130	1,680	717	1,687
Mayaguez (S)									51,322		383	378	16
Rhode Island:													
Providence	7,511	141			140	290		147	106,312	12,320	907	1,510	693
Providence	7,511	141			140	290		147	97,922	12,320	907	1,510	
New Bedford, MA (S)									8,390				
South Carolina:													
Charleston	7,630				143				66,542		464	577	
Columbia	6,878	209		138	251	186			84,106	31,773	1,503	1,328	1,744
Columbia	6,878	209		138	251	186			61,074	31,773	740	541	
Greenville (S)									23,032		763	787	
South Dakota:													
Ft. Meade	3,074	2			15				27,960		183	186	
Hot Springs	3,193				22	41	991	126	16,086		17	76	
Sioux Falls	4,245	40		103	112				27,627	5,095	86	169	405

Tennessee:													
Memphis	14,946	....	....	....	112	....	....	....	167,400	....	1,227	880	....
Mountain Home	6,420	....	....	74	208	....	1,444	....	46,908	....	183	281	....
Murfreesboro	2,319	....	....	90	31	....	....	....	24,965	....	1,153	208	....
Nashville	14,434	250	....	....	108	....	....	....	128,341	21,001	552	634	1,021
Nashville	14,434	250	....	....	108	....	....	....	93,534	21,001	552	634	....
Chattanooga (S)	....	....	....	....	....	....	....	....	18,081	....	....	....	....
Knoxville (S)	....	....	....	....	....	....	....	....	15,126	....	....	....	....
Texas:													
Amarillo	3,477	6	....	....	106	....	....	....	24,880	....	385	349	....
Big Spring	3,047	....	....	130	136	....	....	....	24,400	....	285	170	....
Bonham	2,097	....	....	135	117	....	466	....	18,114	....	174	103	....
Dallas	17,106	181	....	....	481	....	....	....	173,299	38,980	1,520	1,558	1,044
El Paso (I)	....	836	....	....	....	....	....	....	37,307	12,037	706	478	201
Houston	18,358	118	....	130	585	....	....	....	270,201	8,974	2,330	2,858	857
Houston	18,358	118	....	130	585	....	....	....	253,801	8,974	3,087	2,501	857
Beaumont (S)	....	....	....	....	....	....	....	....	16,400	....	252	185	....
Kerrville	3,856	....	....	42	163	....	....	....	25,344	....	156	286	....
Lubbock (I)	....	148	....	....	....	....	....	....	27,354	20,309	660	381	862
Marlin	2,108	3	....	....	83	....	....	....	11,410	....	145	328	....
San Antonio	17,886	373	....	....	401	....	....	....	182,063	9,613	2,176	1,781	830
San Antonio (Morton Minter Blvd.)	17,886	373	....	....	401	....	....	....	130,049	9,523	1,775	1,400	830
Corpus Christi (S)	....	....	....	....	....	....	....	....	16,420	....	401	341	....
McAllen (S)	....	....	....	....	....	....	....	....	6,084	....	....	....	....
San Antonio (Dwyer Ave.)	....	....	....	....	....	....	....	....	29,900	....	....	....	....
Temple	11,820	....	....	....	299	....	1,130	....	60,380	....	373	753	....
Waco	5,613	93	....	127	182	....	....	....	84,660	16,729	171	384	731
Waco (Memorial Dr.)	....	....	....	....	....	....	....	....	77,224	....	....	....	....
Waco (No. Valley Mills Dr.) (S)	....	....	....	....	....	....	....	....	7,376	....	....	....	....
Utah: Salt Lake City	11,020	11	....	143	144	....	....	....	122,676	8,741	546	1,020	299
Vermont: White River Junction	4,016	93	....	126	48	244	....	29	50,349	11,676	273	1,449	206
Virginia:													
Hampton	5,397	13	....	98	122	....	1,036	....	67,693	....	796	792	....
Richmond	15,152	3	....	....	183	....	....	....	133,449	....	1,053	1,342	....
Salem	7,888	253	....	187	187	....	....	....	118,471	43,113	261	253	1,303
Washington:													
American Lake (Tacoma)	2,663	134	....	98	98	....	....	....	28,593	....	385	321	....
Seattle (S)	8,819	387	....	....	375	310	....	421	142,476	37,135	580	1,038	2,898
Spokane	3,846	....	....	....	186	....	....	....	37,801	....	290	335	....
Vancouver	4,740	....	....	....	280	....	....	....	38,735	....	161	343	....
Walla Walla	2,415	....	....	....	66	....	....	....	10,302	....	98	132	....
West Virginia:													
Beckley	4,840	....	....	95	98	....	....	....	26,662	145	138	201	....
Clarksburg	6,085	....	....	....	210	....	....	....	33,979	....	213	204	....
Huntington	2,057	21	....	....	253	....	....	....	36,247	17,480	312	533	1,271
Martinsburg	5,987	3	....	....	240	....	813	....	62,093	2,986	332	353	81
Wisconsin:													
Madison	9,034	....	380	....	67	730	....	94	40,980	....	389	138	....
Tomah	2,000	....	....	131	64	....	....	....	34,480	....	5	130	....
Wood	13,430	435	....	348	352	....	1,124	....	171,867	43,744	2,836	660	2,353
Wyoming:													
Cheyenne	2,872	25	....	86	58	....	....	....	14,590	4,230	215	233	217
Sheridan	1,830	64	....	....	88	....	....	88	10,896	....	274	42	....

[1] D–Independent domiciliary.
I–Independent outpatient clinic.
S–Satellite clinics.
R–Clinics located in regional offices.
N–Nursing Home Care Unit.

[2] As reported by VA authorizing facility.
[3] Authorized and paid for by VA.
[4] Supported by VA.
[5] Medical visits to private physicians authorized by VA on a fee-for-service basis.
[6] Net number of dental cases authorized by VA to private dentists on a fee-for-service basis.

HEALTH CARE

TABLE 11

Applications For Medical Care—Fiscal Years 1978–1979

Item	FY 1979	FY 1978
Total applications	2,508,502	2,498,674
Pending determination of need at beginning of period	2,716	3,777
Received during period	2,505,786	2,494,897
Processed – Total	2,436,202	2,421,902
In need of care	2,052,601	2,007,602
Hospital care	920,042	948,146
Ambulatory care	1,122,858	1,048,501
Nursing home care	4,049	4,274
Domiciliary care	5,652	6,681
Not in need of care	383,601	414,300
Cancelled	69,788	73,331
Pending determination of need at end of period	2,748	2,716
Acceptance rate	84.3%	82.9%

HEALTH CARE

TABLE 12

Total Health Care: Net Full-Time Equivalent Employment Fiscal Years 1978–1979

Appropriation/Fund	FY 1979	FY 1978
Total	191,168	194,294
Medical Care	181,742	184,911
Inpatient Care	153,281	156,152
Hospitals	142,215	144,965
Nursing Homes	8,150	8,107
Domiciliaries	2,916	3,080
Outpatient Care	26,982	27,487
All Other	1,479	1,273
Medical Administration and Miscellaneous Operating Expenses	781	777
Research	4,416	4,367
Medical Research	4,217	4,182
Rehabilitative Research	94	95
Health Services Research	105	90
Canteen Service	3,520	3,406
Supply Fund	709	801
Consolidated Working Fund	...[1]	63

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[1] *Medical Research includes Consolidated Working Fund average employment in FY 1979.*

TABLE 13 | HEALTH CARE

Total Health Care: Operating Costs by Program

	Cost (000)
Total Operating Costs	5,447,958
Medical Care	5,274,756
Inpatient Care	3,875,259
Hospitals	3,480,359
VA hospitals	3,410,449
Contract hospitals	64,812
State home hospitals	5,098
Nursing homes	304,444
VA nursing homes	185,965
Community nursing homes	98,692
State nursing homes	19,787
Domiciliaries	90,456
VA domiciliaries	79,064
State domiciliaries	11,392
Outpatient care	978,220
CHAMPVA	39,218
Education and training	277,040
Miscellaneous benefits and services	105,017
Miscellaneous Operating Expenses	46,877
Medical administration	31,488
Post graduate & inservice training	11,786
Exchange of medical information	3,603
Medical & Prosthetic Research	126,325
Medical research	118,016
Rehabilitative research	5,304
Health services research	3,005

TABLE 14 | HEALTH CARE

VA and Non-VA Facilities: Average Costs—Fiscal Years 1978–1979

Type of Facility	Average Cost per Patient Treated		Average Cost per Patient Day	
	FY 1979	FY 1978	FY 1979	FY 1978
VA Hospitals				
All Bed Sections	2,772	2,583	133.82	119.10
Medical Bed Sections	2,496	2,321	138.44	124.43
Surgical Bed Sections	2,718	2,462	179.25	160.29
Psychiatric Bed Sections	4,918	3,773	95.87	85.46
Non-VA (Contract) Hospitals	2,156	1,944	148.27	121.42
VA Nursing Home Care Units	15,140	14,538	85.86	62.15
Community Nursing Homes	3,480	3,073	32.72	28.42
VA Domiciliaries	4,780	4,350	25.84	23.86
State Homes				
Hospital Care	705	580	11.50[1]	9.90
Nursing Home Care	2,073	2,123	10.13	10.50[1]
Domiciliary Care	1,022	1,029	5.50[1]	5.50[1]

[1] *Per diems reflect statutory limitations.*

TABLE 15

VA Medical Centers—Hospital Care Component, Non-VA (Contract), and State Home Hospitals: Admissions, Discharges, and Remaining by Type of Hospital and Bed Section—Fiscal Year 1979

Type of Facility	Type of Bed Section			
	Total	Medical	Surgical	Psychiatric
ADMISSIONS[1]				
All hospitals	1,196,169	713,214[2]	309,637[2]	168,118[2]
VA Medical Centers – Total	1,162,566	696,361	306,434	159,771
Non-VA (contract) hospitals – Total	28,403	16,853	3,203	8,347
Federal Government Hospitals – Total	2,625	1,837	684	104
Army	1,859	1,236	583	40
Air Force	505	405	90	10
Navy	100	91	7	2
Public Health Service	110	82	4	24
Other[3]	51	23	....	28
State and local government hospitals	6,993	3,479	599	2,915
Non-Public hospitals	17,714	10,806	1,677	5,231
Foreign government hospital[4]	1,071	731	243	97
State home hospitals	5,200	[5]	[5]	[5]
DISCHARGES[1] [6]				
All hospitals	1,195,884	693,280[2]	322,470[2]	174,928[2]
VA Medical Centers – Total	1,162,355	676,402	319,270	166,683
Non-VA (contract) hospitals – Total	28,323	16,878	3,200	8,245
Federal Government Hospitals – Total	2,603	1,826	678	99
Army	103	94	7	2
Air Force	509	406	93	10
Navy	103	94	7	2
Public Health Service	116	87	4	25
Other[3]	54	25	....	29
State and local government hospitals	6,996	3,485	599	2,912
Non-Public hospitals	17,651	10,837	1,674	5,140
Foreign government hospitals[4]	1,073	730	249	94
State home hospitals	5,206	[5]	[5]	[5]
BED OCCUPANTS REMAINING				
Total occupants remaining on September 30, 1979	69,810	32,974[2]	13,540[2]	22,310[2]
VA Medical Centers – Total	67,897	32,702	13,467	21,728
Non-VA (contract) hospitals – Total	927	272	73	582
Federal Government Hospitals – Total	110	71	30	9
Army	91	55	30	6
Air Force	14	14	....	....
Navy	1	1	....	....
Public Health Service	1	....	....	1
Other[3]	3	1	....	2
State and local government hospitals	87	19	4	64
Non-Public hospitals	678	146	28	504
Foreign government hospital[4]	52	36	11	5
State home hospitals	986	[5]	[5]	[5]
ABSENT BED OCCUPANTS REMAINING				
Total absent bed occupants (i.e., patients on leave absence) remaining on September 30, 1979	1,005	205	203	597
VA Medical Centers – Total	983	205	203	575
All other hospitals	22	....	....	22

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[1] *Excludes interhospital transfers for VA medical centers; includes transfers for all other hospitals.*

[2] *Excludes State Home Hospitals; data by bed section not reported.*

[3] *U.S. health care facilities in the Canal Zone area; and St. Elizabeth Hospital, Washington, D.C., which is operated by the Department of Health Education and Welfare.*

[4] *Veterans Memorial Medical Center, Manila, Republic of the Philippines.*

[5] *Data not available.*

[6] *Includes deaths.*

TABLE 16

VA Medical Centers—Hospital Care Component and Non-VA Hospitals: Patient Movement By Type of Bed Section—Fiscal Year 1979

Item	VA Medical Centers				Non-VA Hospitals			
	Total Patients	Type of Bed Section[1]			Total Patients	Type of Bed Section		
		Medical[2]	Surgical	Psychiatric		Medical	Surgical	Psychiatric
Total on rolls (bed occupants and patients on leave of absence) remaining on September 30, 1978	70,149	32,777	13,907	22,765	1,134	339	114	681
Gains during Fiscal Year 1979 – Total	1,335,497	782,470	365,189	186,828	28,501	16,897	3,232	8,372
Admissions	1,162,566	696,361	306,434	158,771	28,403	16,853	3,203	8,347
Transfers in from other hospitals[3]	30,205	12,511	9,568	8,126	....	....	....	....
Changes in bed sections (+)	142,726	73,598	49,187	19,931	98	44	29	25
Losses during Fiscal Year 1979 – Total	1,337,656	783,402	365,314	188,940	28,516	16,973	3,280	8,263
Regular discharges – Total	1,162,365	678,402	319,270	164,693	27,605	16,241	3,135	8,229
To Ambulatory Care	760,472	454,882	247,284	58,306	....	....	....	....
Other	354,053	185,176	63,437	108,040	....	....	....	....
Deaths	46,230	36,344	9,549	337	718	637	65	16
Transfers out to other hospitals[3]	32,592	17,276	9,072	6,244	....	....	....	....
Changes in bed sections (–)	142,709	89,724	36,972	16,013	193	95	80	18
Remaining on September 30, 1979 – Total	67,897	32,702	13,467	21,728	945	272	73	600
Bed occupants	66,914	32,497	13,264	21,153	923	272	73	578
On leave of absence	983	205	203	575	22	....	....	....
Patients treated during the Fiscal Year 1979[6] [7]	1,230,252	709,104	332,737	188,411	29,268	17,150	3,273	8,845
Episodes of care during Fiscal Year 1979[8]	1,372,961	788,828	380,709	204,424	29,461	17,245	3,353	8,863
Average daily census during Fiscal Year 1979[9]	....	....	....	....	....	....	....	....
Total	69,821	34,363	13,825	21,633	1,182	413	107	662
Excluding days while patients on authorized leave of absence of 96 hours or less	68,249	33,854	13,489	20,906	....	....	....	....

[1] *Beds are classified according to their intended use; patients are classified according to the classification of the beds they occupy, rather than on a diagnostic basis.*

[2] *Medical bed sections include medicine, neurology, intermediate care, spinal cord injury, medical rehabilitation, and blind rehabilitation.*

[3] *Include only patients transferred as VA beneficiaries.*

[4] *Included with the data on admissions.*

[5] *Included with the data on "other" regular discharges.*

[6] *Based on the number of discharges and deaths during FY 1979, plus the number remaining on the rolls on September 30, 1979. Interhospital and intrahospital transfers are excluded.*

[7] *Patients coming to VA hospitals for chronic dialysis are considered to be inpatients; there were 224,590 such patients with one day duration of stay treated during the fiscal year.*

[8] *Based on the number of discharges and deaths during FY 1979, plus the number remaining on the rolls on September 30, 1979. Interhospital transfers are excluded but intrahospital transfers are included.*

[9] *Based on the number of patient days divided by the number of days in the fiscal year.*

TABLE 17

VA Medical Centers—Hospital Care Component and Non-VA Hospitals: Patient Movement By Type of Hospital—Fiscal Year 1979

Item	VA Medical Centers-Hospital Care Component	Non-VA (Contract) Hospitals				
		Total	Type of Hospital			
			Federal Government	State and Local Government	Non-Public	Foreign Government
Total on rolls (bed occupants and patients on leave of absence) remaining on September 30, 1978	70,149	1,134	86	74	920	54
Gains during Fiscal Year 1979 – Total	1,335,487	28,501	2,636	7,017	17,717	1,131
Admissions	1,162,556	28,403	2,625	6,993	17,714	1,071
Transfers in from other medical centers[3]	30,205	[4]	[4]	[4]	[4]	[4]
Changes in bed sections (+)	142,726	98	11	24	3	60
Losses during Fiscal Year 1979 – Total	1,337,746	28,516	2,614	6,998	17,771	1,133
Regular discharges – Total	1,162,355	28,323	2,603	6,996	17,651	1,073
To Ambulatory Care	760,472	[5]	[5]	[5]	[5]	[5]
Other	356,653	27,605	2,466	6,826	17,276	1,037
Deaths	45,230	718	137	170	375	36
Transfers out to other medical centers[3]	32,682	[5]	[5]	[5]	[5]	[5]
Changes in bed sections (–)	142,709	193	11	2	120	60
Remaining on September 30, 1979 – Total	67,897	945	110	87	696	52
Bed occupants	66,914	923	110	83	678	52
On leave of absence	983	22	.....	4	18	.....
Patients treated during the fiscal year[6] [7]	1,230,252	29,268	2,713	7,083	18,347	1,125
Episodes of care during the fiscal year[8]	1,372,961	29,461	2,724	7,085	18,467	1,185
Average daily census during the fiscal year[9]						
Total	69,821	1,182	99	180	853	50
Excluding days while patients on authorized leave of absence of 96 hours or less	68,249	......	.....	.....	......	.....

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[1] *Include Department of Defense and Public Health Service hospitals, U.S. health care facilities in the Canal Zone area; and St. Elizabeths Hospital, Washington, D.C., which is operated by the Department of Health, Education and Welfare.*

[2] *Veterans Memorial Medical Center, Manila, Republic of the Philippines.*

[3] *Include only patients transferred as VA beneficiaries.*

[4] *Included with the data on admissions.*

[5] *Included with the data on "other" regular discharges.*

[6] *Based on the number of discharges and deaths during the fiscal year, plus the number on the rolls on September 30, 1979.*

[7] *Patients coming to VA medical centers for chronic dialysis are considered to be inpatients; there were 224,590 such patients with one day duration of stay treated during the fiscal year.*

[8] *Based on the number of discharges and deaths during FY 1979, plus the number remaining on the rolls on September 30, 1979. Interhospital transfers are excluded but intrahospital transfers (i.e., changes in bed sections) are included.*

[9] *Based on the number of patient days during the fiscal year divided by the number of days in the fiscal year.*

VA Medical Centers—Hospital Care Component: Selected Data—Fiscal Year 1979

Location	Average Operating Beds[1]				Patients Treated Total [2] [3]	Episodes of Care[4]			Average Daily Census [1]
	Total	Bed Section[2]				Bed Section[2]			
		Medical [7]	Surgical	Psychiatric		Medical [7]	Surgical	Psychiatric	
All hospitals[5]	87,713	42,772	18,542	26,402	1,230,253	708,828	368,709	204,424	68,821
Alabama:									
Birmingham	428	192	236	....	13,118	8,430	5,851	....	293
Montgomery	168	140	28	....	2,839	2,357	832	....	147
Tuskegee	977	481	95	401	7,140	4,124	1,719	2,787	804
Tuscaloosa	581	143	....	438	4,780	1,161	....	4,168	494
Arizona:									
Phoenix	455	212	107	136	8,810	4,886	2,648	1,954	348
Prescott	211	136	51	24	3,714	2,344	1,218	282	167
Tucson	321	156	119	46	9,962	6,352	3,252	610	267
Arkansas:									
Fayetteville	220	145	75	....	4,958	3,463	1,660	....	168
Little Rock	1,389	532	277	580	18,393	10,437	7,400	3,715	1,122
California:									
Fresno	268	126	107	35	5,058	2,613	2,033	706	207
Livermore	188	105	68	15	2,898	1,794	988	293	132
Loma Linda	317	130	127	60	6,894	4,340	2,348	727	225
Long Beach	1,278	859	267	152	20,984	14,899	5,612	2,128	985
Los Angeles (Brentwood)	468	30	....	438	3,932	488	....	3,756	414
Los Angeles (Wadsworth)	814	554	260	....	18,354	12,691	5,641	....	580
Martinez	426	200	162	64	7,467	4,002	2,983	1,225	330
Palo Alto	1,339	187	140	1,012	13,127	6,295	2,804	5,173	1,019
San Diego	573	270	197	106	15,400	8,924	5,051	1,670	440
San Francisco	354	141	177	36	10,094	5,866	4,084	673	294
Sepulveda	722	339	146	237	10,928	7,379	2,188	2,130	486
Colorado:									
Denver	435	158	180	97	12,136	7,186	4,117	1,580	313
Ft. Lyon	497	185	....	312	1,369	755	....	955	346
Grand Junction	115	83	32	....	2,409	1,790	732	....	92
Connecticut:									
Newington	190	71	84	35	3,848	2,217	1,458	442	134
West Haven	663	373	156	134	11,287	8,571	2,721	1,070	473
Delaware: Wilmington	327	177	150	....	4,472	2,630	2,188	....	254
District of Columbia: Washington	708	327	201	180	17,104	14,063	3,285	1,532	610
Florida:									
Bay Pines	672	385	151	136	7,507	4,990	2,894	1,197	622
Gainesville	480	162	228	90	11,945	5,337	6,184	1,028	384
Lake City	358	274	84	....	7,343	5,720	2,085	....	287
Miami	767	384	217	166	18,078	13,976	5,880	2,446	627
Tampa	697	312	226	159	21,741	16,640	5,810	1,836	580
Georgia:									
Atlanta	503	212	195	96	12,780	7,799	4,130	1,662	386
Augusta	1,076	430	156	490	11,204	5,272	3,273	4,104	787
Dublin	400	355	45	....	6,388	5,150	816	....	317
Idaho: Boise	162	90	72	....	3,077	2,204	1,117	....	97
Illinois:									
Chicago (Lakeside)	447	295	127	25	12,351	10,182	2,754	377	369
Chicago (West Side)	528	253	192	83	8,174	4,305	3,268	1,437	439
Danville	1,070	559	81	430	4,630	2,880	1,347	2,279	797
Hines	1,347	776	331	240	23,960	17,521	5,108	2,490	1,061
Marion	171	126	45	....	3,381	2,396	1,262	....	136
North Chicago	1,421	533	98	790	6,158	3,918	1,174	3,072	1,046
Indiana:									
Ft. Wayne	177	110	67	....	2,813	2,842	1,093	....	128
Indianapolis[9]	587	280	210	97	13,326	8,583	4,805	1,261	429
Marion	986	719	....	267	3,326	2,440	....	1,878	806
Iowa:									
Des Moines	278	147	131	....	8,550	3,952	3,042	....	214
Iowa City	350	150	148	52	11,002	7,519	2,954	856	256
Knoxville	678	277	....	401	3,161	1,049	....	1,838	453
Kansas:									
Leavenworth	473	200	121	152	8,839	2,958	1,845	2,775	353
Topeka	904	333	57	514	5,192	3,182	830	2,273	743
Wichita	183	101	82	....	4,326	3,342	1,427	....	126
Kentucky:									
Lexington[10]	882	436	148	298	12,087	7,780	3,844	1,880	736
Louisville	425	194	182	49	8,994	4,166	3,841	831	311
Louisiana:									
Alexandria	366	242	108	16	5,850	4,158	2,491	844	290
New Orleans	578	253	231	94	11,858	7,653	2,808	1,046	416
Shreveport	445	221	150	74	9,160	6,424	3,342	1,745	297
Maine: Togus	583	180	78	325	7,494	3,826	1,530	2,747	476
Maryland:									
Baltimore	279	130	109	40	8,469	3,621	2,684	1,347	217
Ft. Howard	230	213	....	17	2,036	1,866	....	222	198
Perry Point	787	400	....	387	2,881	2,123	....	1,503	720
Massachusetts:									
Bedford	803	326	43	434	3,332	1,751	429	1,934	703
Boston	807	438	277	92	14,680	8,844	6,309	1,087	642
Brockton	848	335	15	498	3,869	1,501	190	2,725	731

See footnotes at end of table.

VA Medical Centers—Hospital Care Component: Selected Data—Fiscal Year 1979—Continued

Location	Average Operating Beds[1]				Patients Treated Total[2 3]	Episodes of Care[4]			Average Daily Census[5]
	Total	Bed Section[6] Medical[7]	Bed Section[6] Surgical	Bed Section[6] Psychiatric		Bed Section[6] Medical[7]	Bed Section[6] Surgical	Bed Section[6] Psychiatric	
Northampton	776	348	....	428	2,802	1,552	....	2,251	581
West Roxbury	264	181	83	....	4,496	3,037	2,050	....	199
Michigan:									
Allen Park	552	283	150	119	12,001	8,232	2,680	1,857	408
Ann Arbor	337	148	90	100	11,632	8,014	2,841	1,018	267
Battle Creek	968	329	....	639	4,290	1,122	....	3,869	794
Iron Mountain	219	130	89	....	4,013	3,005	1,106	....	140
Saginaw	160	102	58	....	3,870	2,499	1,319	....	118
Minnesota:									
Minneapolis	776	340	334	103	20,158	12,869	7,484	1,520	588
St. Cloud	836	414	....	422	2,801	1,349	....	2,078	739
Mississippi:									
Biloxi	822	261	66	495	6,661	2,481	2,381	2,831	680
Jackson	472	225	178	70	12,078	7,225	4,295	1,160	389
Missouri:									
Columbia	392	180	152	60	7,833	4,340	3,480	723	288
Kansas City	470	218	185	67	12,002	8,219	3,738	1,080	378
Poplar Bluff	176	89	77	10	3,969	2,118	1,794	345	146
St. Louis	934	417	233	284	14,096	8,669	4,152	2,803	696
Montana:									
Ft. Harrison	157	99	58	....	3,305	2,208	1,329	....	114
Miles City	94	64	30	....	2,141	1,586	629	....	59
Nebraska:									
Grand Island	162	111	51	....	2,832	2,141	831	....	115
Lincoln	178	59	65	54	3,785	1,957	1,318	1,199	133
Omaha	401	191	143	67	8,857	6,107	2,611	940	314
Nevada: Reno	179	85	70	24	4,093	2,385	1,624	374	131
New Hampshire: Manchester	162	100	62	....	3,798	2,649	1,375	....	136
New Jersey:									
East Orange	958	591	252	115	18,240	12,603	3,658	1,522	780
Lyons	1,273	503	27	743	4,014	1,838	447	3,051	1,039
New Mexico: Albuquerque	364	163	137	64	9,351	7,092	4,278	1,232	281
New York:									
Albany	695	365	198	132	8,646	4,841	3,098	1,925	578
Batavia	240	210	30	....	2,202	2,348	609	....	201
Bath	208	197	....	11	1,440	1,299	....	228	197
Bronx	702	392	250	60	14,632	11,051	3,797	799	544
Brooklyn[11]	1,050	639	295	116	18,008	13,174	3,884	2,296	840
Buffalo	791	458	199	134	12,848	7,961	3,795	2,202	681
Canandaigua	1,018	532	8	478	3,340	1,911	110	2,297	859
Castle Point	254	189	65	....	2,475	1,617	1,129	....	187
Montrose	1,283	444	15	824	4,600	1,059	294	3,943	1,100
New York	952	441	360	151	13,852	7,157	5,574	1,806	749
Northport	838	381	150	307	10,847	6,530	3,046	2,113	698
Syracuse	362	132	166	64	9,706	2,820	2,834	521	288
North Carolina:									
Asheville	535	350	155	30	8,384	5,471	3,433	473	438
Durham	497	200	216	81	10,688	6,639	4,575	827	390
Fayetteville	339	224	83	33	5,342	3,908	1,451	341	244
Salisbury	874	324	40	510	5,823	2,757	841	3,228	754
North Dakota: Fargo	224	152	72	....	4,234	3,595	1,184	....	148
Ohio:									
Chillicothe	940	462	....	478	4,883	4,119	....	2,978	780
Cincinnati	375	120	177	78	10,514	6,384	3,914	1,007	309
Cleveland	1,466	563	259	644	14,845	9,119	3,384	4,549	1,123
Dayton	814	309	215	290	7,127	4,132	2,452	1,290	608
Oklahoma:									
Muskogee	240	137	103	....	4,862	3,250	1,837	....	157
Oklahoma City	433	169	157	107	14,261	10,868	4,849	1,800	340
Oregon:									
Portland	485	273	182	30	12,484	9,329	3,426	498	349
Roseburg	353	184	22	147	3,766	2,332	629	1,298	278
Pennsylvania:									
Altoona	120	86	34	....	1,835	1,217	673	....	117
Butler	313	313	....	....	2,933	3,009	....	....	223
Coatesville	1,392	431	....	961	4,304	1,195	....	3,914	1,102
Erie	142	100	42	....	2,858	1,966	1,252	....	123
Lebanon	846	396	29	421	3,224	2,240	630	1,124	698
Philadelphia	477	233	201	44	8,887	6,372	2,064	575	373
Pittsburgh (Highland Drive)	817	309	....	508	3,686	1,146	....	3,257	690
Pittsburgh (University Drive)[11]	692	435	226	31	11,905	9,085	3,674	439	534
Wilkes-Barre	491	258	121	112	8,051	3,336	1,589	1,575	384
Puerto Rico: San Juan	691	278	173	240	17,278	10,640	4,006	3,384	594
Rhode Island: Providence	334	213	82	39	7,511	5,988	1,730	563	252
South Carolina:									
Charleston	408	206	148	54	7,630	4,084	3,216	841	316
Columbia	412	217	159	36	6,879	3,954	3,150	693	342
South Dakota:									
Ft. Meade	402	212	17	173	3,074	1,256	693	1,538	344
Hot Springs	222	147	31	44	3,193	2,963	589	663	169
Sioux Falls	249	126	84	39	4,345	2,340	1,738	493	186

See footnotes at end of table.

TABLE 18—Continued

VA Medical Centers—Hospital Care Components: Selected Data—Fiscal Year 1979—Continued

Location	Average Operating Beds[1]				Patients Treated Total [2] [3]	Episodes of Care[4]			Average Daily Census [5]
	Total	Bed Section[6]				Bed Section[6]			
		Medical [7]	Surgical	Psychiatric		Medical [7]	Surgical	Psychiatric	
Tennessee:									
Memphis	904	518	206	180	14,945	9,358	5,309	1,944	980
Mountain Home	610	301	136	73	6,420	3,330	2,324	1,516	429
Murfreesboro	758	436	....	322	2,319	739	....	1,771	687
Nashville	485	233	206	46	14,434	11,204	4,332	598	393
Texas:									
Amarillo	139	76	63	....	3,477	2,323	1,337	....	112
Big Spring	221	128	62	30	3,547	3,376	1,545	456	163
Bonham	78	39	24	15	2,007	1,451	795	154	68
Dallas	712	301	251	160	17,106	10,489	6,317	1,888	551
Houston	1,137	511	255	372	18,358	12,349	6,841	2,827	924
Kerrville	306	238	68	....	3,955	3,105	1,105	....	236
Marlin	222	222	....	....	2,106	2,250	....	....	143
San Antonio	679	263	216	180	17,856	12,776	5,003	1,636	563
Temple	636	337	209	90	11,628	7,916	3,534	1,245	485
Waco	1,031	400	....	631	6,613	1,688	....	4,503	918
Utah: Salt Lake City	454	229	115	110	11,020	6,845	3,719	1,482	334
Vermont: White River Junction	194	95	79	20	4,018	2,212	1,768	244	161
Virginia:									
Hampton	459	288	96	75	6,397	3,616	1,913	695	360
Richmond	759	506	188	65	15,152	11,959	3,984	920	606
Salem	776	274	76	426	7,608	3,524	1,710	4,109	633
Washington:									
American Lake	478	142	....	336	2,863	1,198	....	1,939	380
Seattle	303	139	98	66	8,819	6,069	2,301	964	262
Spokane	213	118	95	....	3,845	2,501	1,767	....	170
Vancouver	356	182	108	57	4,740	2,905	1,821	642	254
Walla Walla	162	129	33	....	2,415	1,989	606	....	117
West Virginia:									
Beckley	174	114	60	....	4,840	3,446	1,911	....	133
Clarksburg	215	91	87	37	6,089	3,799	2,295	703	183
Huntington	164	106	58	....	3,057	2,003	1,252	....	123
Martinsburg	514	420	72	22	5,987	4,707	1,536	405	464
Wisconsin:									
Madison	378	201	159	18	9,034	6,558	3,182	297	261
Tomah	800	447	....	353	3,080	1,389	....	2,113	704
Wood	815	369	249	197	13,430	8,272	4,282	2,191	651
Wyoming:									
Cheyenne	129	80	49	....	2,972	2,400	674	....	105
Sheridan	332	127	....	206	1,820	1,082	....	1,205	272

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[1] *Based on the number of operating beds at the end of each month or 13 consecutive months (September 1978 – September 1979).*

[2] *Based on the number of discharges and deaths during FY 1979, plus the number on the rolls (bed occupants and patients on authorized leave of absence) on September 30, 1979. Interhospital transfers are excluded from the overall total but are included in the individual hospital totals.*

[3] *Beginning with FY 1973, patients coming to VA hospitals for chronic dialysis are considered to be inpatients; there were 224,590 such patients during FY 1979.*

[4] *Based on the number of discharges and deaths during FY 1979, plus the number on the rolls (bed occupants and patients on authorized leave of absence) on September 30, 1979. Interhospital transfers are excluded from the overall totals but are included in the individual bed section totals. Intrahospital transfers (i.e., movement of patients from one type of bed section to another) are included in both the overall bed section totals and in the individual hospital bed section totals.*

[5] *Based on total patient days during FY 1979 divided by the number of days in the fiscal year.*

[6] *Beds are classified according to their intended use; patients are classified according to the classification of the beds they occupy, rather than on diagnostic basis.*

[7] *Medical bed sections include medicine, neurology, intermediate care, spinal cord injury, medical rehabilitation, and blind rehabilitation.*

[8] *Data for the VA Medical Centers at Augusta (Lenwood), GA, Brecksville, OH, Gulfport, MS, Jefferson Barracks, MO, North Little Rock, AR, and Palo Alto (Menlo Park), CA are included, respectively, with the data for the VA Medical Centers at Augusta, Cleveland, Biloxi, St. Louis, Little Rock, and Palo Alto.*

[9] *Includes data for the two VA Medical Centers at Indianapolis, IN, (Cold Spring Road and West 10th Street).*

[10] *Includes data for the two VA Medical Centers at Lexington, KY, (Cooper Drive and Leestown).*

[11] *Includes data for the VA Medical Centers at Brooklyn and St. Albans, NY.*

[12] *Includes data for the VA Medical Centers at Pittsburgh (University Drive) and Aspinwall, PA.*

Non-VA Hospitals[1] : Selected Data—Fiscal Year 1979

Location of Authorizing VA Facility	Average Daily Census [3]	Admissions	Discharges [3]	Patients Treated[2]				Remaining on Sept. 30, 1979 [4]
				Total	Federal Hospitals	State and Local Government Hospitals [5]	Non-Public Hospitals	
Total	1,182	29,403	29,323	29,288	3,858	7,083	18,347	954
Medical Bed Sections	588	16,853	16,878	17,150	2,683	3,504	10,963	272
Surgical Bed Sections	107	3,203	3,200	3,273	968	603	1,702	73
Psychiatric Bed Sections	487	9,347	9,245	8,865	207	2,976	5,682	609
Alabama:								
Montgomery	4	275	276	277	7	170	100	3
Tuscaloosa	....	3	3	3	....	3	....	....
Alaska: Juneau (RO)	90	3,283	3,306	3,380	258	185	2,937	70
Arizona:								
Phoenix	7	224	219	228	1	55	172	9
Tucson[6]	1	80	80	81	....	81	....	1
Arkansas: Little Rock	5	403	403	403	....	....	403	....
California:								
Loma Linda	1	38	40	41	....	....	41	....
Los Angeles (OPC)	13	674	660	660	....	311	349	....
Martinez	....	2	3	3	....	....	3	....
Palo Alto	....	....	1	1	....	1	....	....
San Diego	1	134	133	134	....	41	93	1
San Francisco	8	673	673	673	1	265	407	....
Colorado: Denver	2	212	209	209	7	57	145	....
Connecticut: Newington	2	136	132	136	....	73	63	4
Delaware: Wilmington	....	8	8	8	....	....	8	....
District of Columbia: Washington	5	69	72	75	72	....	3	3
Florida:								
Bay Pines	58	3,010	3,019	3,048	43	1,543	1,462	27
Gainesville	....	5	5	5	....	....	5	....
Lake City	....	6	6	6	....	....	6	....
Miami	4	396	394	398	....	398	....	4
Tampa	1	39	39	39	....	....	39	....
Georgia:								
Atlanta	7	418	415	418	....	418	....	3
Augusta	....	15	16	16	....	16	....	....
Hawaii: Honolulu (RO)	86	1,690	1,643	1,736	939	410	387	93
Idaho: Boise	3	251	251	251	....	155	96	....
Illinois:								
Chicago (L.S.)	....	4	5	5	....	....	5	....
Chicago (W.S.)	13	341	342	342	....	150	192	....
Marion	....	12	13	13	....	13	....	....
Indiana: Indianapolis	8	257	258	259	....	72	187	1
Iowa:								
Des Moines	....	58	58	58	....	22	36	....
Iowa City	1	188	188	188	....	161	27	....
Kansas: Wichita	2	52	54	55	....	2	53	1
Kentucky: Louisville	2	121	121	121	2	23	96	1
Louisiana:								
Alexandria	....	2	2	2	....	....	2	....
New Orleans	8	79	77	81	....	8	73	6
Shreveport	2	91	91	91	1	....	90	....
Maine: Togus	7	148	150	150	....	....	150	....
Maryland: Baltimore	2	78	75	79	....	2	77	4
Massachusetts:								
Bedford	....	6	6	6	....	....	6	....
Boston (OPC)	8	285	284	287	....	10	277	1
Northampton	13	27	27	27	....	27	....	....
Michigan:								
Allen Park	12	485	485	485	3	243	239	....
Iron Mountain	1	44	44	44	....	44	....	....
Minnesota: Minneapolis	8	307	307	308	....	115	193	1
Mississippi: Jackson	2	113	113	113	....	91	22	....
Missouri:								
Columbia	2	160	161	162	....	162	....	1
Kansas City	3	174	174	174	....	....	174	....
St. Louis	4	41	41	41	1	....	40	....
Montana: Ft. Harrison	4	229	231	232	....	....	232	1
Nebraska: Lincoln	3	62	62	63	....	13	50	1
Nevada: Reno	5	240	236	241	....	20	221	7
New Hampshire: Manchester	1	112	112	112	....	22	90	....
New Jersey: East Orange	4	155	152	155	....	49	106	3
New Mexico: Albuquerque	2	89	89	89	....	....	89	....
New York:								
Albany	2	41	41	41	....	4	37	....
Bath	....	10	10	10	....	....	10	....
Brooklyn	4	89	93	93	93	....	....	....
Brooklyn (OPC)	3	129	129	129	....	112	17	....
Buffalo	4	146	146	147	....	44	103	1
New York	15	184	167	175	....	157	18	8
Syracuse	2	219	219	219	....	....	219	....

See footnotes at end of table.

Non-VA Hospitals[1] : Selected Data—Fiscal Year 1979—Continued

Location of Authorizing VA Facility	Average Daily Census [2]	Admissions	Discharges [3]	Patients Treated[4]				Remaining on Sept. 30, 1979 [5]
				Total	Federal Hospitals	State and Local Government Hospitals [6]	Non-Public Hospitals	
North Carolina:								
Asheville	......	14	14	15	......	......	15	1
Salisbury	5	177	177	177	......	49	128	......
North Dakota: Fargo	3	393	397	406	274	1	131	9
Ohio:								
Cincinnati	3	159	158	158	......	73	85	......
Cleveland	5	307	307	307	......	14	293	......
Columbus (OPC)	7	165	166	167	......	81	86	1
Oklahoma:								
Muskogee	6	71	72	72	......	72	......	......
Oklahoma City	......	48	48	48	......	48	......	......
Oregon:								
Portland	7	413	413	413	......	29	384	......
White City (DOM)	2	117	114	118	......	......	118	4
Pennsylvania:								
Altoona	4	190	182	191	......	......	191	9
Butler	......	13	13	13	......	13	......	......
Coatesville	......	15	15	15	......	15	......	......
Erie	1	59	60	60	......	60	......	......
Lebanon	1	94	96	97	......	15	82	1
Philadelphia	8	431	459	462	17	66	379	3
Pittsburgh (GM&S)	2	56	56	56	......	......	56	......
Pittsburgh (PSY)	1	21	21	21	......	......	21	......
Wilkes-Barre	3	151	152	153	......	28	125	1
Philippines: Manila (RO)	90	1,076	1,076	1,136	1,125	......	11	60
Puerto Rico: San Juan	941	3,858	3,777	4,315	......	37	4,278	538
Rhode Island: Providence	3	139	141	141	......	14	127	......
South Carolina: Columbia	5	203	205	212	6	86	120	7
South Dakota:								
Ft. Meade	......	2	2	2	......	2	......	......
Sioux Falls	1	40	40	40	......	2	38	......
Tennessee: Nashville	5	249	248	250	......	107	143	2
Texas:								
Amarillo	......	3	3	3	......	......	3	......
Dallas	3	181	180	181	......	95	86	1
El Paso (OPC)	28	820	811	838	748	67	123	27
Houston	1	118	118	118	......	16	102	......
Lubbock (OPC)	4	146	149	149	......	1	148	......
Marlin	......	3	3	3	......	......	3	......
San Antonio	9	263	262	273	107	33	133	11
Waco	2	91	91	92	......	51	41	1
Utah: Salt Lake City	......	11	11	11	......	......	11	......
Vermont: White River Junction	2	87	92	93	......	3	90	1
Virginia:								
Hampton	......	12	12	13	......	......	13	1
Richmond	......	20	20	20	......	20	......	......
Salem	8	246	247	253	2	6	245	6
Washington:								
American Lake	......	129	129	134	131	3	......	5
Seattle	5	385	380	386	......	163	223	6
West Virginia:								
Huntington	2	21	21	21	......	21	......	......
Martinsburg	......	3	3	3	......	3	......	......
Wisconsin: Wood	8	434	425	425	......	16	409	......
Wyoming:								
Cheyenne	......	25	25	25	......	24	1	......
Sheridan	1	64	64	64	......	......	64	......

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[1] *Exclude State Home hospitals.*

[2] *Based on the number of patient days during the fiscal year divided by the number of days in the year.*

[3] *Includes deaths.*

[4] *Discharges and deaths during the fiscal year plus the number of patients on the rolls at the end of the fiscal year.*

[5] *Total on rolls (bed occupants and patients on authorized leave of absence).*

[6] *1257 patients (816 in medical bed section, 346 in surgical bed section, 95 in psychiatric bed section) treated in Non-Federal hospital.*

TABLE 20

VA Medical Centers—Hospital Care Component: Patients Remaining, Type of Patient, Percent Hospitalized in Reported State of Residence¹ —September 26, 1979

Reported State of Residence	All Patients			Type of Patient									
				General Medical and Surgical		Tuberculosis		Psychotic		Other Psychiatric		Neurological	
	Total	Hospitalized in Same State		Total	Percent Hospitalized in Same State	Total	Percent Hospitalized in Same State	Total	Percent Hospitalized in Same State	Total	Percent Hospitalized in Same State	Total	Percent Hospitalized in Same State
		Number	Percent										
Total	68,894	60,357	88.2	32,024	88.0	482	90.2	17,769	84.1	12,099	85.3	7,820	85.8
United States	68,248	59,734	88.1	31,654	87.9	482	90.2	17,581	83.9	12,044	85.3	7,587	85.8
Alabama	1,440	1,286	87.3	617	85.3	19	73.7	474	89.7	177	90.4	162	87.8
Alaska	9	....	0.0	9	0.0	....	0.0	....	0.0	....	0.0	....	0.0
Arizona	817	751	91.9	483	91.7	9	100.0	101	89.1	123	95.9	101	90.1
Arkansas	1,060	960	90.6	574	89.5	5	100.0	177	86.4	160	100.0	144	88.6
California	5,096	4,897	96.2	2,587	98.0	26	80.8	947	96.2	973	92.6	547	95.1
Colorado	614	536	87.3	264	88.6	11	100.0	116	90.5	169	80.5	54	92.6
Connecticut	683	503	73.6	368	94.5	....	0.0	184	33.2	61	70.5	72	73.6
Delaware	208	127	61.1	111	100.0	....	0.0	47	12.8	29	0.0	21	52.4
District of Columbia	416	354	85.1	229	97.8	10	100.0	46	30.4	102	90.2	30	50.0
Florida	2,716	2,346	86.4	1,618	93.6	35	100.0	418	56.5	295	85.6	350	97.1
Georgia	1,559	1,131	72.5	747	74.4	10	80.0	381	58.7	306	78.8	135	86.7
Hawaii	4	....	0.0	4	0.0	....	0.0	....	0.0	....	0.0	....	0.0
Idaho	188	89	47.3	131	54.2	....	0.0	29	41.4	17	35.3	11	0.0
Illinois	3,893	3,430	88.1	1,881	86.4	18	100.0	839	93.8	581	82.7	484	89.7
Indiana	1,622	1,261	77.7	896	73.9	15	86.7	696	84.3	242	75.2	104	63.5
Iowa	839	667	80.0	383	80.2	4	0.0	223	88.8	136	81.6	83	61.4
Kansas	975	645	66.1	413	50.6	6	100.0	256	89.1	198	67.2	103	67.0
Kentucky	1,283	964	75.1	680	72.6	5	0.0	209	90.6	258	79.1	131	58.5
Louisiana	1,097	869	79.2	642	96.7	20	80.0	196	31.6	133	58.6	106	95.3
Maine	433	426	98.6	172	96.5	....	0.0	134	100.0	89	100.0	38	100.0
Maryland	1,255	863	68.8	489	57.1	....	0.0	237	92.4	257	70.8	272	67.6
Massachusetts	2,571	2,420	94.1	700	87.2	5	100.0	1,047	97.6	484	97.8	305	93.4
Michigan	1,807	1,679	92.6	650	93.5	14	71.4	650	98.5	346	90.2	147	86.4
Minnesota	1,336	1,179	88.3	461	83.1	6	100.0	589	91.9	199	87.9	160	91.9
Mississippi	937	721	76.9	476	78.2	....	0.0	227	73.1	146	91.1	88	56.8
Missouri	1,530	1,212	79.2	814	67.2	5	100.0	231	56.7	226	85.9	154	84.4
Montana	308	173	56.2	203	60.0	5	100.0	29	0.0	46	39.1	25	40.0
Nebraska	689	426	61.8	345	78.4	....	0.0	154	17.5	157	68.2	33	57.6
Nevada	210	96	45.7	142	50.0	6	100.0	16	43.8	27	25.9	19	31.6
New Hampshire	281	109	38.8	164	50.6	....	0.0	58	10.3	27	22.2	32	40.6
New Jersey	2,041	1,740	85.3	636	83.3	26	100.0	830	85.4	279	63.8	270	88.9
New Mexico	298	217	72.8	178	89.3	6	100.0	51	33.3	42	54.8	21	57.1
New York	6,910	6,694	96.9	2,906	97.9	55	100.0	2,053	94.6	1,060	97.5	836	98.1
North Carolina	1,784	1,629	91.3	852	95.2	6	100.0	439	92.3	277	88.4	211	77.3
North Dakota	154	72	46.8	70	77.1	....	0.0	50	0.0	30	43.3	4	100.0
Ohio	2,882	2,517	87.9	1,134	87.4	11	100.0	800	88.9	598	87.3	319	90.4
Oklahoma	634	427	67.4	360	90.8	4	100.0	106	20.8	114	50.0	50	34.0
Oregon	774	577	74.5	447	85.0	15	33.3	81	75.1	151	49.7	70	62.9
Pennsylvania	4,161	3,836	92.2	1,394	91.8	24	100.0	1,536	91.7	787	95.6	420	88.3
Rhode Island	261	182	69.7	131	91.6	....	0.0	67	25.4	22	40.9	41	87.8
South Carolina	1,166	705	60.5	711	72.2	9	100.0	175	33.1	144	38.8	127	53.5
South Dakota	578	486	84.1	254	76.0	....	0.0	119	90.8	186	94.0	39	74.4
Tennessee	1,732	1,656	95.6	770	98.2	28	100.0	456	90.6	303	95.7	166	98.4
Texas	4,276	4,082	95.5	2,201	98.2	41	100.0	880	94.0	808	94.3	348	96.8
Utah	308	253	82.1	154	90.3	....	0.0	69	42.4	69	92.8	29	100.0
Vermont	152	108	71.1	71	93.0	....	0.0	27	29.6	25	76.0	29	48.4
Virginia	1,685	1,329	78.6	786	81.0	16	100.0	360	75.3	251	80.1	332	81.0
Washington	1,009	977	96.9	461	91.5	....	0.0	215	94.9	208	91.8	125	79.2
West Virginia	672	592	87.9	485	88.0	10	100.0	113	15.9	162	47.5	102	70.6
Wisconsin	1,592	1,413	88.8	684	87.4	....	0.0	382	85.6	273	95.2	153	88.3
Wyoming	251	201	80.1	71	70.4	....	0.0	60	83.3	111	86.6	9	95.6
Outside United States	646	623	96.4	370	94.9	....	0.0	186	100.0	55	90.9	33	100.0
Canal Zone	0	....	0.0	....	0.0	....	0.0	....	0.0	....	0.0	....	0.0
Philippines, Republic of	0	....	0.0	....	0.0	....	0.0	....	0.0	....	0.0	....	0.0
Puerto Rico	632	....	0.0	354	0.0	....	0.0	186	0.0	85	0.0	33	0.0
Others	14	....	0.0	14	0.0	....	0.0	....	0.0	....	0.0	....	0.0

¹*Figures shown are estimates based on tabulations of a 20 percent systematic random sample of records for patients remaining on September 26, 1979. The figures shown in the column for all patients do not necessarily equal the sum of the component parts due to machine rounding of sample data.*

TABLE 21

VA Medical Centers—Hospital Care Component: Patients Remaining, Percent By Attained Stay, Diagnostic Grouping[1]—September 26, 1979

Diagnostic Composition of Patients	Percent in Each Diagnostic Category for Specified Length of Stay							
	Number of Patients	90 Days or Less	91 Days or More	Inpatient Stay More Than (Years)				
				1	2	5	10	20
All patients	69,994	70.1	29.9	17.7	12.3	5.9	2.7	1.5
Tuberculosis	482	68.9	31.1	6.6	1.2	.0	.0	.0
Pulmonary tuberculosis	424	68.4	31.6	7.5	1.4	.0	.0	.0
Other tuberculosis	58	72.9	27.1	.0	.0	.0	.0	.0
Psychoses	17,769	40.2	59.8	41.6	30.8	18.6	8.8	5.1
Other psychiatric	12,099	68.9	31.1	18.3	12.3	4.6	1.2	.4
Neurological	7,620	57.5	42.5	23.6	15.6	6.6	2.0	.6
Vascular lesions affecting central nervous system	2,809	59.1	40.9	21.8	12.6	3.6	.4	.2
Other neurological	4,762	56.2	43.8	24.9	17.5	8.5	3.0	.9
Neurological diseases of the sense organs	49	100.0	.0	.0	.0	.0	.0	.0
General medical and surgical	32,024	90.0	10.0	2.9	1.5	.4	.1	.0
Infective and parasitic diseases	354	82.2	17.8	7.6	6.2	1.4	.0	.0
Malignant neoplasms	5,403	92.0	8.0	1.1	.5	.2	.0	.0
Benign and unspecified neoplasms	492	100.0	.0	.0	.0	.0	.0	.0
Allergic and endocrine system	1,606	83.8	16.2	7.8	3.7	1.8	.3	.3
Heart diseases and symptoms	3,666	88.5	11.5	5.1	2.3	.8	.2	.2
Vascular diseases	2,539	85.2	14.8	3.6	2.1	.8	.4	.0
Acute respiratory diseases	569	92.3	7.7	.9	.0	.0	.0	.0
Other respiratory diseases with asthma and symptoms	2,605	87.7	12.3	4.3	2.6	.4	.0	.0
Diseases of the digestive system and symptoms	4,567	94.8	5.2	1.2	.7	.2	.0	.0
Diseases of the genitourinary system and symptoms	2,269	93.8	6.2	1.3	.7	.2	.0	.0
Diseases of skin and cellular tissue	1,273	87.4	12.6	5.7	2.4	.8	.0	.0
Diseases of bones and organs of movement and symptoms	2,268	89.1	10.9	3.5	2.2	.2	.0	.0
Accidents, poisonings and violence	2,344	87.8	12.2	1.7	.4	.0	.0	.0
All other	2,072	90.2	9.8	2.3	1.4	.2	.0	.0

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[1] *Figures shown are estimates based on tabulations of a 20 percent random sample of records for patients remaining on September 26, 1979. The figures shown in the column for "number of patients" do not necessarily equal the sum of the component parts due to machine rounding of sample data.*

VA Medical Centers—Hospital Care Component: Patients Remaining, Diagnostic Category, Period of Service, Average Age and Age Group¹—September 26, 1979

Principal Diagnosis	All Patients	Period of Service: Vietnam Era	Post Korean	Korean Conflict	WW II	WW I	All Others	Average Age	Age Group: Under 35	35-44	45-54	55-64	65-74	75-84	85 and Over
All diseases and conditions	[illegible]	9,760	4,480	7,820	[illegible]	5,844	[illegible]	59.6	[illegible]	[illegible]	14,437	22,794	10,022	[illegible]	[illegible]
I. Infective and parasitic diseases	860	116	47	71	614	67	43	58.9	97	43	227	257	141	40	42
Pulmonary tuberculosis (011)	433	21	22	46	290	21	16	58.2	.....	26	104	109	81	27	16
Tuberculosis, late effects (019)	14	.....	.....	5	.....	4	4	(¹)	.....	.....	5	.....	4	4	.....
Tuberculosis, other (010, 012-018)	40	5	.....	.....	30	.....	5	(¹)	10	.....	10	10	5	.....	.....
Cardiovascular syphilis (093)	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Syphilis of central nervous system (094)	5	.....	.....	.....	5	.....	4	(¹)	.....	.....	.....	.....	5	4	.....
Other forms of late syphilis, latent, or unspecified (090-097)	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
All other venereal diseases ([illegible])	15	5	.....	.....	5	.....	5	(¹)	10	.....	.....	5	.....	.....	.....
Infectious hepatitis (070)	22	10	.....	.....	12	.....	.....	(¹)	10	.....	.....	12	.....	.....	.....
Malaria (084)	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
All other infective and parasitic diseases (000-009, 020-027, 030-039, 040-046, 050-057, 060-068, 071-079, 080-083, 085-089, 100-104, 110-117, 120-129, 130-136)	327	72	10	22	[illegible]	41	10	[illegible]	67	5	72	[illegible]	46	19	[illegible]
II. Neoplasms	6,112	317	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	61.2	[illegible]	[illegible]	1,131	2,077	[illegible]	[illegible]	[illegible]
Malignancy of buccal cavity and pharynx (140-149)	687	27	9	74	437	[illegible]	6	58.2	.....	11	[illegible]	270	[illegible]	14	6
Malignancy of digestive organs and peritoneum (150-159)	[illegible]	14	9	[illegible]	[illegible]	[illegible]	[illegible]	63.7	.....	14	167	[illegible]	[illegible]	[illegible]	[illegible]
Malignancy of respiratory system (160, 162-163)	[illegible]	[illegible]	62	153	[illegible]	[illegible]	[illegible]	61.2	5	20	[illegible]	757	331	[illegible]	16
Malignancy of larynx (161)	294	16	5	[illegible]	[illegible]	21	10	[illegible]	.....	6	[illegible]	129	40	21	.....
Malignancy of lymphatic and hematopoietic tissue (200-209)	[illegible]	[illegible]	20	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	41	21	[illegible]	201	75	21	[illegible]
Malignancy of genitourinary organs (180-189)	[illegible]	16	5	30	[illegible]	[illegible]	5	68.1	10	6	[illegible]	[illegible]	217	[illegible]	[illegible]
Malignancies of all other systems (170-174, 190-199)	[illegible]	64	77	46	[illegible]	70	[illegible]	[illegible]	51	44	176	[illegible]	180	[illegible]	61
Neoplasms, benign (210-228)	[illegible]	42	21	[illegible]	[illegible]	[illegible]	20	[illegible]	[illegible]	16	46	116	31	21	16
Neoplasms, of unspecified nature (230-239)	[illegible]	33	20	30	210	42	.....	[illegible]	16	[illegible]	46	120	62	42	11
III. Endocrine, nutritional, and metabolic diseases	[illegible]	[illegible]	[illegible]	230	1,060	[illegible]	44	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	276	110	27
Diabetes mellitus (250)	[illegible]	70	70	[illegible]	[illegible]	77	34	[illegible]	28	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	32
Diseases of thyroid and other endocrine glands (240-246, 251-258)	177	16	15	10	110	14	4	[illegible]	10	20	21	[illegible]	[illegible]	10	5
Avitaminosis and other nutritional deficiency (260-269)	[illegible]	5	.....	.....	[illegible]	5	.....	(¹)	.....	.....	10	27	[illegible]	5	.....
Obesity not specified as of endocrine origin (277)	[illegible]	.....	5	27	30	.....	5	(¹)	.....	11	21	[illegible]	.....	.....	.....
Other metabolic diseases (270-276, 278-279)	72	4	6	4	47	10	.....	(¹)	4	6	19	23	10	10	.....
IV. Diseases of blood and blood-forming organs	[illegible]	5	4	[illegible]	173	[illegible]	21	[illegible]	[illegible]	.....	67	[illegible]	46	61	30
Anemia, iron deficiency (280)	[illegible]	.....	.....	15	15	[illegible]	.....	(¹)	.....	.....	[illegible]	15	.....	5	5
Pernicious anemia (281.0)	21	.....	.....	.....	[illegible]	[illegible]	.....	(¹)	.....	.....	6	.....	11	[illegible]	.....
Anemia, other (281.1-285)	[illegible]	.....	4	5	[illegible]	46	21	64.7	15	.....	15	[illegible]	[illegible]	[illegible]	24
All other diseases of blood and blood-forming organs (286-289)	[illegible]	5	.....	10	[illegible]	16	.....	(¹)	5	.....	[illegible]	24	10	[illegible]	.....
V. Mental disorders	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	51.4	[illegible]	[illegible]	[illegible]	7,770	3,118	[illegible]	[illegible]
Alcoholic psychosis (291)	[illegible]	43	13	[illegible]	[illegible]	15	[illegible]	[illegible]	29	[illegible]	212	421	167	26	5
Psychosis associated with drug dependence ([illegible])	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Psychosis associated with organic brain syndrome, excluding alcohol and drug dependence ([illegible])	[illegible]	[illegible]	161	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	61	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Psychosis not attributed to physical conditions (295-299)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	442	1,149	[illegible]	[illegible]	[illegible]	[illegible]	3,474	[illegible]	[illegible]	167
Alcoholism (303)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	13	[illegible]	47.6	1,072	[illegible]	[illegible]	1,207	310	[illegible]	16
Non-psychotic organic brain syndrome associated with alcoholism (309.13)	[illegible]	7	.....	25	310	10	6	[illegible]	.....	7	30	100	114	25	5
Drug dependence (304)	[illegible]	551	48	20	48	.....	135	[illegible]	[illegible]	65	43	16	.....	5	.....
Non-psychotic organic brain syndrome associated with drug dependence (309.14)	20	.....	5	.....	15	.....	5	(¹)	5	5	5	10	.....	.....	.....
Non-psychotic organic brain syndrome associated with other physical conditions (309.0, 309.2-309.9)	2,030	118	101	106	1,633	[illegible]	105	[illegible]	48	104	333	[illegible]	[illegible]	[illegible]	435
Mental retardation (310-315)	53	.....	.....	12	40	.....	.....	(¹)	.....	.....	10	23	5	5	.....
All other non-psychotic mental disorders (V00.1, V63.4, 300-302, 305-307, 316, 318, 783.0)	2,403	781	264	197	1,061	27	153	48.6	747	277	[illegible]	[illegible]	181	35	4
VI. Diseases of nervous system and sense organs	[illegible]	[illegible]	[illegible]	[illegible]	2,348	221	207	50.7	383	[illegible]	610	1,391	637	255	66
Inflammatory diseases of central nervous system (320-324)	83	15	.....	10	53	.....	5	(¹)	10	15	14	34	.....	4	.....
Epilepsy (345)	183	20	11	10	66	.....	26	50.6	20	10	36	66	36	.....	.....
Amyotrophic lateral sclerosis (348.0)	43	5	.....	.....	27	6	.....	(¹)	.....	.....	5	17	16	6	.....
Paraplegia, cerebral or spinal (344.2, 349.2)	383	67	61	91	164	.....	25	48.2	67	70	105	139	16	.....	.....
Quadriplegia, cerebral or spinal (344.3, 349.4)	535	111	62	92	194	6	66	47.8	161	63	165	101	66	18	4
Other diseases of central nervous system, including hereditary and familial disease of nervous system (330-333, 340-344.1, 344.9, 346-347, 348.1-349.2, 350.0-349.9)	1,838	158	134	247	[illegible]	104	90	57.3	80	178	422	671	214	125	29
Diseases of nerves and peripheral ganglia (350-358)	301	36	5	51	184	15	21	56.7	26	21	68	112	53	24	.....
Inflammatory diseases of the eye and other conditions of the eye, except blindness, (360-369), (370, 378)	547	15	10	20	400	77	10	64.1	10	25	60	210	140	74	25
Blindness (379)	53	5	.....	11	36	.....	.....	(¹)	.....	5	17	26	4	.....	.....
Disease of ear and mastoid process (380-389)	69	15	[illegible]	20	40	5	5	(¹)	5	5	30	25	10	10	4
VII. Diseases of the circulatory system	[illegible]	354	250	718	[illegible]	1,106	330	63.5	193	180	[illegible]	3,040	[illegible]	[illegible]	520
Chronic rheumatic heart disease (393-398)	130	12	6	14	74	10	12	58.6	7	5	30	40	25	6	10
Hypertensive heart disease, exclusive of ischemic heart disease (402.1, 402, 404)	37	.....	.....	5	32	.....	.....	(¹)	.....	.....	10	5	5	.....	.....
Hypertensive disease without heart involvement (400.0, 400.2, 400.3, 400.9, 401, 403)	367	14	20	41	272	15	4	55.7	6	20	107	132	83	6	10
Acute myocardial infarction (410)	530	13	16	40	411	25	16	61.7	.....	14	100	230	107	67	4
Chronic ischemic heart disease (412)	[illegible]	49	26	113	781	260	51	68.6	4	31	166	470	235	266	161
Other ischemic heart disease, with or without hypertensive disease (411, 413-414)	420	17	15	45	316	10	10	57.6	5	20	142	167	39	10	6
Other forms of heart disease (391, 392.0, 420-429)	1,216	57	25	75	854	108	10	64.4	33	25	141	475	275	187	38
Cerebral hemorrhage (431)	72	5	.....	11	51	5	.....	(¹)	5	6	10	26	15	10	.....
Cerebral thrombosis (433)	254	14	.....	5	210	20	5	66.4	5	5	34	110	71	10	5
Cerebral embolism (434)	4	.....	.....	.....	.....	4	.....	(¹)	.....	.....	.....	.....	.....	.....	4
Generalized ischemic cerebrovascular disease (437)	136	5	.....	.....	97	30	4	67.7	4	.....	10	33	31	50	5
All other cerebrovascular disease (430, 432, 435, 436, 438)	3,340	55	63	137	[illegible]	371	50	66.7	.....	10	287	923	[illegible]	394	116
Arteriosclerosis (440)	271	10	5	17	169	60	12	67.4	6	.....	25	110	45	46	44
All other diseases of arteries, arterioles and capillaries (441-448)	1,181	31	35	111	[illegible]	90	21	62.5	5	15	260	[illegible]	312	54	43
Varicose veins lower extremities (454)	170	.....	10	20	111	15	14	61.1	5	5	25	90	25	20	.....
Hemorrhoids (455)	127	34	14	18	58	.....	5	48.4	10	20	30	44	6	.....	.....
All other diseases of veins and lymphatics, and other diseases of circulatory system (390, 392.9, 450-453, 456-458)	412	46	15	60	242	20	24	56.1	40	10	102	184	76	21	10
VIII. Diseases of the respiratory system	[illegible]	187	90	167	1,875	349	113	63.1	81	101	416	[illegible]	[illegible]	348	148
Acute respiratory infections including influenza (460-466, 470-474)	43	4	.....	5	21	12	.....	(¹)	.....	4	10	5	12	12	.....
Pneumonia (480-486)	499	44	15	26	274	100	38	68.2	15	36	59	135	103	101	48
Bronchitis, unqualified and chronic (490-491)	158	18	.....	9	113	16	.....	62.6	.....	14	33	55	33	21	11
Emphysema (492)	815	18	30	27	601	121	37	66.4	.....	5	60	305	284	100	57
Asthma (493)	130	10	10	21	83	5	.....	58.3	.....	10	52	45	15	5	.....
All other diseases of upper respiratory tract and respiratory system (500-508, 510-519)	1,250	72	47	110	875	91	60	60.6	67	31	213	434	300	107	30

VA Medical Centers—Hospital Care Component: Patients Remaining, Diagnostic Category, Period of Service, Average Age and Age Group¹—September 26, 1979—Continued

Principal Diagnosis²	All Patients	Period of Service						Average Age⁶	Age Group						
		Vietnam Era	Post Korea³	Korean Conflict⁴	WW II	WW I	All Others⁵		Under 35	35-44	45-54	55-64	65-74	75-84	85 and Over
IX. Diseases of the digestive system	4,153	408	274	543	2,552	383	126	57.1	380	281	1,020	1,535	538	275	120
Diseases of oral cavity, salivary glands, and jaws (520-529)	90	10	.....	10	54	5	10	(⁶)	10	5	10	40	10	9	5
Ulcers digestive system (stomach, duodenum, peptic, gastrojejunal) (531-534)	385	27	30	46	218	38	14	58.5	16	35	64	171	30	42	5
All other diseases esophagus, stomach, and duodenum (except ulcers) (530, 535-537)	254	14	24	24	150	31	11	60.0	19	9	46	99	60	15	16
Hernia of abdominal cavity (550-553)	706	61	54	62	446	53	30	57.9	46	35	197	281	98	67	12
Other diseases of intestine and peritoneum (540-543) (560-569)	1,068	121	18	133	623	125	25	56.9	102	32	203	391	171	103	64
Alcoholic cirrhosis of liver (571.0)	563	36	70	146	390	.....	20	53.8	14	84	287	237	88	.....	4
Other diseases of liver, gallbladder and pancreas (570, 571.8, 571.9, 572-577)	1,010	132	76	132	623	51	18	58.3	72	61	273	424	150	40	30
X. Diseases of the genitourinary system	2,019	158	93	143	1,391	255	80	61.5	140	128	198	758	458	184	156
Nephritis and Nephrosis (580-584)	287	31	34	42	246	23	31	60.3	31	30	99	101	46	20	13
Other diseases of urinary system (590-599)	832	88	44	78	485	124	31	61.2	60	65	169	284	175	80	71
Diseases of the prostate (600-602)	628	.....	4	23	477	107	16	68.5	.....	5	12	220	223	75	71
Other diseases of male genital organs (603-607)	126	41	5	.....	68	.....	10	48.5	36	10	14	48	15	.....	.....
Diseases of the breast, gynecological conditions (610-616, 620-629)	39	9	6	.....	18	.....	18	(⁶)	14	10	.....	15	.....	.....	.....
XI. Deliveries and complications of pregnancy, childbirth and the puerperium	.....	.....	.....	.....	.....	.....	.....		.....	.....	.....	.....	.....	.....	.....
Diseases and complications of pregnancy, childbirth and the puerperium (630-678)	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
XII. Diseases of skin and subcutaneous tissue	1,273	207	99	147	709	68	48	54.5	163	106	232	480	176	83	29
Infections of skin and subcutaneous tissue (680-686, 694-698)	589	94	51	64	337	4	40	51.9	104	61	109	234	48	34	.....
All other diseases of skin and subcutaneous tissue (690-693, 700-709)	683	113	48	83	371	62	8	56.9	59	45	114	231	128	49	29
XIII. Diseases of the musculoskeletal system and connective tissue	2,175	294	163	201	1,338	91	89	56.6	220	190	445	888	301	101	40
Arthritis and rheumatism, except rheumatic fever (710-718)	872	37	59	61	644	41	29	59.9	37	30	132	424	167	43	30
Displacement of intervertebral disc (725)	179	48	24	28	78	.....	5	48.0	41	30	40	52	10	6	.....
Osteomyelitis and other diseases of bone and joint (720-724, 726-729)	755	162	50	90	384	39	29	52.2	117	89	194	238	61	43	12
Other diseases of musculoskeletal system (730-738)	371	49	36	23	230	11	29	55.5	24	36	79	152	63	9	8
XIV. Congenital deformities (740-759)	62	10	.....	10	37	5	.....	(⁶)	5	.....	16	16	20	5	.....
XVI.a Symptoms and ill defined conditions	2,238	258	140	228	1,302	237	127	58.3	143	100	446	814	297	263	85
Senility without mention of psychosis (794)	9	.....	.....	.....	.....	9	.....	(⁶)	.....	.....	.....	.....	.....	.....	9
Symptoms and all other ill-defined conditions (780-792, 795-796)	2,229	258	140	228	1,302	228	127	58.2	143	100	446	814	297	253	76
XVI.b Observation and examination cases, follow-up and special admissions	482	51	29	68	283	31	21	56.9	34	62	99	194	87	26	9
Tuberculosis (Y03.01, Y03.02, Y10.01-Y10.03)	9	.....	.....	.....	9	.....	.....	(⁶)	.....	.....	.....	5	4	.....	.....
Malignancy (793.1, Y03.3)	72	.....	.....	5	47	15	5	(⁶)	.....	.....	5	36	16	15	.....
All other admissions (793.8, 793.9, Y00.0, Y00.01, Y00.09, Y00.2-Y01, Y03.02, Y03.91-Y03.94, Y04-Y06, Y10.0-Y10.8, Y10.60, Y10.64-Y10.69, Y10.9, Y11-Y12, Y20-Y29)	427	51	28	63	233	18	16	56.2	34	62	94	130	80	10	9
Diagnosis deferred, mental observation (319.0 APA code)	4	.....	.....	.....	4	.....	.....	(⁶)	.....	.....	.....	4	.....	.....	.....

XVII. Accidents, poisonings, and nature of injury	2,882	586	197	227	1,391	279	263	52.4	631	392	585	788	371	212	129
Fracture of skull and facial bones (800-804)	84	21	5	5	38	.....	12	([4])	27	5	21	14	16	.....	.....
Fracture of skull and facial bones, late effects (800-804)[7]	21	5	.....	5	5	.....	6	([4])	6	10	.....	5	.....	.....	.....
Fracture of spine and trunk (805-809)	261	43	20	47	130	10	22	61.7	48	30	77	74	28	10	5
Fracture of spine and trunk, late effects (805-809)[7]	40	5	5	.....	20	.....	10	([4])	15	.....	10	15	.....	.....	.....
Fracture of upper limb (810-819)	115	21	5	5	59	14	.....	56.7	27	5	9	31	29	14	.....
Fracture of upper limb, late effects (810-819)[7]	41	5	5	.....	27	5	.....	([4])	5	5	10	17	.....	.....	5
Fracture of lower limb (820-829)	861	81	56	72	480	163	30	61.5	91	32	181	233	169	121	76
Fracture of lower limb, late effects (820-829)[7]	54	5	.....	.....	30	15	4	([4])	5	.....	5	5	20	4	15
Dislocation without fracture (830-839)	60	16	16	10	20	.....	5	([4])	21	7	20	15	.....	.....	.....
Dislocation without fracture, late effects (830-839)[7]	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Intracranial injury without skull fracture (850-854)	182	53	20	10	45	10	64	42.4	83	23	25	40	.....	5	5
Intracranial injury without skull fracture, late effects (850-854)[7]	108	34	.....	4	46	5	20	46.5	34	15	19	35	.....	5	.....
Internal injury of chest, abdomen and pelvis (860-869)	26	.....	.....	.....	15	5	5	([4])	5	.....	5	5	5	.....	5
Internal injury of chest, abdomen and pelvis, late effects (860-869)[7]	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Traumatic amputation of arm and hand-complete/partial (887)	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Traumatic amputation of arm and hand-complete/partial, late effects (887)[7]	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Traumatic amputation of foot and leg(s)-complete/partial (896-897)	30	.....	.....	10	20	.....	.....	([4])	.....	.....	.....	15	15	.....	.....
Traumatic amputation of foot and leg(s)-complete/partial, late effects (896-897)[7]	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Burns (940-949)	72	10	9	5	30	5	4	([4])	16	5	15	16	19	.....	5
Burns, late effects (940-949)[7]	5	5	.....	.....	.....	.....	.....	([4])	5	.....	.....	.....	.....	.....	.....
Injury to nerves and spinal cord (950-959)	123	49	11	5	58	.....	.....	48.6	19	26	25	53	5	.....	.....
Injury to nerves and spinal cord, late effects (950-959)[7]	20	10	.....	6	6	.....	7	([4])	10	.....	16	.....	.....	.....	.....
Adverse effect of medicinal agents and other complications of surgical and medical care (960-979, 997-999)	390	87	15	12	221	24	31	53.4	88	10	70	131	90	25	5
All other accidents, poisonings and violence (840-848, 870-879, 880-886, 890-895, 900-907, 910-918, 920-929, 930-939, 980-994)	340	88	16	31	123	22	63	47.5	117	15	70	88	16	28	4
All other accidents, poisonings and violence, late effects (870-879, 880-880, 890-895, 900-907, 910-918, 920-929)[7]	16	16	.....	.....	.....	.....	.....	([4])	11	5	.....	.....	.....	.....	.....

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[1] Figures shown are estimates based on tabulations of a 20 percent systematic random sample of records of patients remaining on September 26, 1979. The figures shown in the column for "All Patients" do not necessarily equal the sum of the component parts due to machine rounding of sample data.

[2] The diagnostic categories and selected diagnoses included in this table are based on the "International Classification of Diseases Adapted for Indexing of Hospital Records," USPHS Pub. No. 1693. The numbers following the diagnoses are the identifying code numbers of this diagnostic classification. Category XV, "Certain Causes of Perinatal Morbidity and Mortality," in which no cases occurred, is not included in this table.

[3] Service between February 1, 1955 and August 4, 1964.

[4] Service between June 22, 1950 and January 31, 1955.

[5] Consists of 31 Spanish Americans, 1,298 peacetime, 1,076 post Vietnam, 235 active military and 61 nonveterans.

[6] Average age not calculated for totals less than 100 cases.

[7] All late effect codes are differentiated from other codes by being uniformly .9 in the fourth digit position.

VA Medical Centers—Hospital Care Component: Patients Remaining, Age, Diagnostic Grouping[1] *September 26, 1979*

Diagnostic Composition of Patients	All Patients		Age Distribution							
			Under 55		55-64		65-74		75 and Over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All patients	69,994	100.0	28,773	100.0	22,754	100.0	10,522	100.0	7,945	100.0
Tuberculosis	482	.7	193	.7	159	.7	94	.9	36	.5
Pulmonary tuberculosis	424	.6	172	.6	139	.6	81	.8	32	.4
Other tuberculosis	59	.1	21	.1	20	.1	13	.1	4	.1
Psychoses	17,769	25.4	9,692	33.7	4,798	21.1	1,833	17.4	1,446	18.2
Other psychiatric	12,098	17.3	6,625	23.0	2,972	13.1	1,282	12.2	1,218	15.3
Neurological	7,620	10.9	2,695	9.4	2,680	11.8	1,322	12.6	923	11.6
Vascular lesions affecting central nervous system	2,809	4.0	397	1.4	1,089	4.8	727	6.9	596	7.5
Other neurological	4,762	6.8	2,271	7.9	1,581	6.9	589	5.6	322	4.1
Neurological diseases of the sense organs	49	.1	29	.1	10	......	7	.1	5	.1
General medical and surgical	32,024	45.8	9,567	33.2	12,145	53.4	5,991	56.9	4,321	54.4
Infective and parasitic diseases	354	.5	153	.5	103	.5	48	.4	51	.6
Malignant neoplasms	5,403	7.7	1,221	4.2	2,313	10.2	1,184	11.3	685	8.6
Benign and unspecified neoplasms	492	.7	163	.6	189	.8	69	.7	72	.9
Allergic and endocrine system	1,606	2.3	578	2.0	606	2.7	275	2.6	147	1.9
Heart diseases and symptoms	3,666	5.2	774	2.7	1,446	6.4	686	6.5	760	9.6
Vascular diseases	2,529	3.6	682	2.4	1,015	4.5	545	5.2	286	3.6
Acute respiratory diseases	569	.8	134	.5	146	.6	121	1.1	168	2.1
Other respiratory diseases with asthma and symptoms	2,605	3.7	582	2.0	931	4.1	734	7.0	358	4.5
Diseases of the digestive system and symptoms	4,559	6.5	1,710	6.0	1,800	7.9	600	5.7	449	5.7
Diseases of the genitourinary system and symptoms	2,269	3.2	519	1.8	830	3.6	511	4.9	409	5.1
Diseases of skin and cellular tissue	1,273	1.8	520	1.8	466	2.0	175	1.7	112	1.4
Diseases of bones and organs of movement and symptoms	2,266	3.2	896	3.1	908	4.0	305	2.9	158	2.0
Accidents, poisonings and violence	2,344	3.3	1,024	3.6	634	2.8	365	3.5	320	4.0
All other	2,072	3.0	591	2.1	759	3.3	374	3.6	347	4.4

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[1] *Figures shown are estimates based on tabulations of a 20 percent random sample of records for patients remaining on September 26, 1979. The figures shown in the column for "number of patients" do not necessarily equal the sum of the component parts due to machine rounding of sample data.*

VA Medical Centers—Hospital Care Component: Patients Remaining, Age Groups ByState[1]
September 26, 1979

VA Medical Center and State	Total all Patients	Age Group					
		Under 25	25-34	35-44	45-54	55-64	65 and Over
All VA medical centers	70,004	1,828	7,042	5,467	14,443	22,758	18,466
Alabama:							
Birmingham	312	....	19	9	56	130	98
Montgomery	137	....	....	....	12	44	81
Tuscaloosa	498	22	71	43	140	140	82
Tuskegee	769	14	83	60	193	207	212
Arizona:							
Phoenix	382	4	63	27	67	111	110
Prescott	179	....	....	....	46	61	72
Tucson	232	10	20	6	31	77	88
Arkansas:							
Fayetteville	186	....	18	9	32	59	68
Little Rock	361	10	15	29	73	141	93
Little Rock (North)	652	24	62	73	125	212	156
California:							
Fresno	208	....	24	....	42	73	69
Livermore	137	....	....	11	11	47	68
Loma Linda	287	....	35	31	47	90	84
Long Beach	999	15	110	91	229	309	245
Los Angeles (Brentwood)	401	53	87	47	113	82	19
Los Angeles (Wadsworth)	559	....	49	49	108	157	196
Martinez	325	4	7	15	67	103	129
Palo Alto	553	30	87	24	55	223	134
Palo Alto (Menlo Park)	466	14	189	69	97	74	23
San Diego	449	6	43	26	80	171	123
San Francisco	283	6	15	15	51	101	95
Sepulveda	441	17	74	53	87	97	113
Colorado:							
Denver	325	19	11	23	53	151	68
Fort Lyon	356	10	48	48	82	86	82
Grand Junction	102	....	10	5	5	41	41
Connecticut:							
Newington	141	7	12	19	20	59	24
West Haven	452	34	53	39	64	148	114
Delaware: Wilmington	283	6	11	6	72	116	72
District of Columbia: Washington	599	9	105	58	156	177	94
Florida:							
Bay Pines	607	12	52	23	74	176	270
Gainesville	388	16	39	15	111	145	62
Lake City	262	....	4	8	66	106	78
Miami	632	9	77	43	162	206	135
Tampa	571	17	46	51	132	236	89
Georgia:							
Augusta (Forest Hills)	264	....	10	15	88	132	19
Augusta (Lenwood)	521	....	70	81	144	154	72
Decatur	400	24	53	39	112	126	46
Dublin	276	....	....	9	58	89	120
Idaho: Boise	96	6	18	....	12	12	48
Illinois:							
Chicago (Lakeside)	385	27	14	9	89	142	104
Chicago (Westside)	477	5	54	38	94	168	118
Danville	726	26	82	41	112	187	278
Hines	1,120	51	127	99	274	386	183
Marion	132	....	....	....	20	56	56
North Chicago	991	15	136	121	244	311	164
Indiana:							
Fort Wayne	151	4	16	33	16	49	33
Indianapolis	454	21	48	25	86	174	100
Marion	784	11	63	75	232	207	196
Iowa:							
Des Moines	206	5	10	....	34	103	54
Iowa City	272	5	9	20	45	148	45
Knoxville	406	16	32	32	112	82	132
Kansas:							
Leavenworth	329	4	8	45	55	145	72
Topeka	736	14	106	79	129	221	187
Wichita	102	....	12	....	....	48	42
Kentucky:							
Lexington	763	8	62	85	135	278	195
Louisville	314	8	19	25	67	148	47

See footnote at end of table.

VA Medical Centers—Hospital Care Component: Patients Remaining, Age Groups By State[1] September 26, 1979—Continued

VA Medical Center and State	Total all Patients	Age Group					
		Under 25	25-34	35-44	45-54	55-64	65 and Over
Louisiana:							
Alexandria	308	....	16	33	61	143	55
New Orleans	407	21	43	52	79	145	67
Shreveport	269	16	22	11	38	92	90
Maine: Togus	472	....	79	10	127	156	100
Maryland:							
Baltimore	230	7	18	....	78	96	31
Fort Howard	193	....	23	....	46	69	55
Perry Point	728	11	46	61	138	241	231
Massachusetts:							
Bedford	702	21	63	42	114	186	276
Boston	633	17	76	41	120	194	185
Brockton	751	22	75	94	155	247	158
Northampton	564	13	52	39	147	211	102
West Roxbury	213	27	27	37	53	48	21
Michigan:							
Allen Park	425	26	58	51	72	137	81
Ann Arbor	302	12	25	11	79	148	27
Battle Creek	810	24	177	101	191	209	108
Iron Mountain	136	11	17	....	17	34	57
Saginaw	125	....	10	5	26	42	42
Minnesota:							
Minneapolis	644	18	44	66	132	229	155
St. Cloud	728	6	74	63	171	143	271
Mississippi:							
Biloxi	165	4	....	4	18	36	103
Biloxi (Gulfport)	536	21	106	37	156	154	62
Jackson	405	14	47	23	83	128	110
Missouri:							
Columbia	306	8	15	50	46	101	86
Kansas City	375	10	39	30	84	123	89
Poplar Bluff	156	....	25	5	40	35	51
St. Louis (Jefferson Barracks)	382	19	71	52	101	96	43
St. Louis (John J. Cochran)	286	5	10	5	68	121	77
Montana:							
Fort Harrison	115	5	....	5	30	45	30
Miles City	63	4	....	....	17	21	21
Nebraska:							
Grand Island	86	....	....	13	7	33	33
Lincoln	136	4	24	11	24	34	39
Omaha	317	9	64	12	57	109	66
Nevada: Reno	136	....	13	6	33	39	45
New Hampshire: Manchester	141	....	....	....	13	90	38
New Jersey:							
East Orange	807	16	62	74	172	230	253
Lyons	1,032	4	72	59	240	364	293
New Mexico: Albuquerque	251	6	29	17	41	94	64
New York:							
Albany	590	14	23	24	81	197	251
Batavia	203	....	4	4	36	52	107
Bath	194	....	8	5	10	31	140
Bronx	524	16	54	51	73	173	157
Brooklyn	828	....	69	80	112	305	262
Buffalo	665	30	45	55	86	164	285
Canandaigua	894	19	61	80	187	216	331
Castle Point	198	16	8	21	25	62	66
Montrose	1,096	25	118	121	243	365	224
New York	726	10	87	60	155	208	206
Northport	844	15	76	45	153	322	233
Syracuse	248	11	19	16	27	74	101
North Carolina:							
Asheville	454	....	30	15	56	194	159
Durham	405	5	48	43	88	172	49
Fayetteville	260	....	26	17	43	107	67
Salisbury	747	5	67	31	212	278	154
North Dakota: Fargo	164	13	9	22	22	31	67
Ohio:							
Chillicothe	777	33	48	73	227	207	189
Cincinnati	293	23	40	17	52	120	41
Cleveland (Brecksville)	662	42	132	127	188	105	68
Cleveland (Wade Park)	461	15	35	15	99	175	122
Dayton	585	9	32	19	141	188	196

See footnote at end of table.

VA Medical Centers—Hospital Care Component: Patients Remaining, Age Groups By State[1] September 26, 1979—Continued

VA Medical Center and State	Total all Patients	Age Group					
		Under 25	25-34	35-44	45-54	55-64	65 and Over
Oklahoma:							
Muskogee	137	....	4	18	31	62	22
Oklahoma City	312	4	61	9	48	108	82
Oregon:							
Portland	360	....	47	14	69	104	126
Roseburg	338	36	18	52	74	66	92
Pennsylvania:							
Altoona	124	....	....	17	6	45	56
Butler	215	5	11	....	27	70	102
Coatesville	1,099	54	139	117	249	354	186
Erie	132	....	13	13	22	40	44
Lebanon	813	22	46	46	201	279	220
Philadelphia	359	11	31	19	49	168	81
Pittsburgh (Highland Drive)	677	32	70	48	134	248	146
Pittsburgh (University Drive)	521	10	16	13	60	168	256
Wilkes-Barre	394	5	20	16	67	159	128
Puerto Rico: San Juan	628	24	145	66	139	162	92
Rhode Island: Providence	249	9	4	....	49	111	76
South Carolina:							
Charleston	342	6	38	22	44	126	106
Columbia	391	....	40	31	77	124	119
South Dakota:							
Fort Meade	306	....	48	32	61	83	82
Hot Springs	168	....	....	17	56	45	50
Sioux Falls	192	4	34	8	12	59	75
Tennessee:							
Memphis	700	19	105	46	175	240	115
Mountain Home	433	....	33	19	89	133	159
Murfreesboro	613	9	41	43	95	239	186
Nashville	418	18	41	29	84	131	115
Texas:							
Amarillo	111	5	5	5	21	43	32
Big Spring	188	....	5	16	81	33	53
Bonham	53	....	4	3	7	15	24
Dallas	560	19	76	30	128	203	104
Houston	915	43	88	104	204	270	205
Kerrville	263	6	11	....	65	56	126
Marlin	154	....	....	4	13	47	90
San Antonio	568	5	73	34	106	236	114
Temple	509	18	38	26	97	151	178
Waco	921	47	111	84	278	248	153
Utah: Salt Lake City	334	10	50	50	31	111	82
Vermont: White River Junction	162	....	21	13	41	60	27
Virginia:							
Hampton	329	9	38	22	74	86	100
Richmond	622	22	65	32	137	256	110
Salem	630	16	61	44	174	182	153
Washington:							
American Lake	395	....	66	78	84	90	77
Seattle	247	10	24	20	30	95	68
Spokane	180	6	....	19	31	87	37
Vancouver	276	....	27	20	44	90	95
Walla Walla	106	5	11	11	21	32	26
West Virginia:							
Beckley	161	....	6	....	17	69	69
Clarksburg	181	....	9	8	24	55	85
Huntington	105	....	....	14	10	48	33
Martinsburg	470	5	16	29	66	192	162
Wisconsin:							
Madison	294	5	11	13	27	130	108
Tomah	696	....	47	67	159	171	252
Wood	693	30	66	30	167	183	207
Wyoming:							
Cheyenne	120	....	....	24	29	48	19
Sheridan	265	....	19	40	52	78	76

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[1] *Figures shown are estimates based on a tabulation of a 20 percent systematic random sample of records for patients remaining on September 26, 1979. The figures shown in the column for 'All Patients' do not necessarily equal the sum of the component parts due to machine rounding of sample data.*

VA Medical Centers—Hospital Care Component: Patients Remaining, Compensation and Pension Status, Type of Patient, Age[1]—September 26, 1979

Type of Patient and Age Group	Total All Patients	Service Connected Veterans				Non-Service Connected			Non-Veterans[3]
		Total	10% or More	Less than 10%	NSC with SC[2]	Total	Pension	Other	
All patients	69,995	20,737	11,563	691	8,483	49,013	18,645	30,368	245
Under 25	1,830	506	424	5	77	1,174	94	1,080	150
25-34	7,041	2,691	2,048	99	544	4,306	548	3,758	44
35-44	5,465	1,856	1,410	37	409	3,600	598	3,002	9
45-54	14,438	3,937	2,352	145	1,440	10,486	4,031	6,455	15
55-64	22,754	7,242	3,512	247	3,483	15,506	6,020	9,486	6
65 and over	18,466	4,505	1,817	158	2,530	13,940	7,353	6,587	21
Tuberculosis	482	77	61	0	16	405	174	231	0
Under 25	0	0	0	0	0	0	0	0	0
25-34	0	0	0	0	0	0	0	0	0
35-44	38	4	4	0	0	34	0	34	0
45-54	155	22	11	0	11	133	52	81	0
55-64	159	12	12	0	0	147	61	86	0
65 and over	130	39	34	0	5	91	61	30	0
Psychotic	17,769	7,721	6,446	262	1,013	9,961	4,486	5,475	87
Under 25	807	326	302	0	24	414	61	353	67
25-34	2,910	1,577	1,405	50	122	1,318	252	1,066	16
35-44	1,951	985	911	5	69	961	261	700	5
45-54	4,022	1,579	1,334	82	163	2,443	1,460	983	0
55-64	4,798	2,193	1,749	80	364	2,605	1,407	1,198	0
65 and over	3,278	1,058	744	44	270	2,220	1,045	1,175	0
Other psychiatric	12,098	2,722	1,248	101	1,373	9,342	2,623	6,719	34
Under 25	473	57	42	0	15	392	0	392	24
25-34	2,081	418	226	7	185	1,659	114	1,545	4
35-44	1,365	290	136	16	138	1,075	89	986	0
45-54	2,705	538	249	4	285	2,167	588	1,579	0
55-64	2,972	912	395	59	458	2,054	781	1,273	6
65 and over	2,501	507	229	15	264	1,994	1,051	943	0
Neurological	7,620	1,760	919	32	809	5,801	2,234	3,567	59
Under 25	156	29	24	0	5	94	9	85	33
25-34	499	168	142	5	21	315	71	244	16
35-44	553	156	112	0	44	397	81	316	0
45-54	1,487	336	219	10	107	1,146	451	695	5
55-64	2,680	655	311	5	339	2,025	751	1,274	0
65 and over	2,244	415	110	11	294	1,824	871	953	5
General medical and surgical	32,024	8,457	2,890	295	5,272	23,503	9,127	14,376	64
Under 25	392	93	55	5	33	274	24	250	25
25-34	1,549	526	274	36	216	1,015	112	903	9
35-44	1,560	421	245	15	161	1,134	168	966	5
45-54	6,068	1,463	540	48	875	4,595	1,479	3,116	10
55-64	12,145	3,469	1,075	103	2,291	8,676	3,020	5,656	0
65 and over	10,313	2,486	701	88	1,697	7,811	4,325	3,486	16

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[1] *Figures shown are estimates based on tabulations of a 20 percent systematic random sample of records of patients remaining on September 26, 1979. The figures shown in column for 'All Patients' do not necessarily equal the sum of the component parts due to the machine rounding of sample data.*

[2] *Veterans with compensable SC disabilities but treated for non-service-connected disabilities only.*

[3] *This group includes all patients other than veterans, such as active military, humanitarian emergencies, reimbursable cases, allied beneficiaries, donors, etc. If veteran is admitted as an Office of Workers Compensation Case, he is coded as a non-veteran.*

TABLE 26

VA Medical Centers—Hospital Care Component: Patients Discharged, Manner of Disposition, Diagnostic Grouping[1]— Fiscal Year 1979

Type of Patient	Total All Discharges	Regular	Type of Disposition			Unavailable[2]
			Irregular	Total Deaths	Transfers to Further VA Inpatient Care at VA or Non-VA Hospital	
All discharges	926,775	804,257	47,941	42,474	31,785	318
Tuberculosis	3,829	3,327	149	184	168	1
Pulmonary tuberculosis	2,602	2,215	122	139	125	1
Other tuberculosis	1,227	1,112	27	45	43	....
Psychoses	78,524	57,298	14,310	1,106	5,780	30
Other psychiatric	134,032	107,860	21,317	1,143	3,677	35
Neurological	58,145	49,986	1,128	3,706	3,299	26
Vascular lesions affecting central nervous system	18,069	14,865	149	2,218	826	11
Other neurological	39,186	34,279	965	1,485	2,442	15
Neurological diseases of the sense organs	890	842	14	3	31	....
General medical and surgical	645,455	579,987	10,670	35,864	18,715	219
Infective and parasitic diseases	9,259	8,237	157	738	124	3
Malignant neoplasms	81,703	63,570	647	14,094	3,360	32
Benign and unspecified neoplasms	10,611	10,011	121	88	387	4
Allergic and endocrine system	27,925	26,083	531	745	560	6
Heart diseases and symptoms	85,079	73,398	1,328	7,006	3,306	41
Vascular diseases	39,216	35,715	594	1,650	1,243	14
Acute respiratory diseases	15,733	12,884	221	2,414	207	7
Other respiratory diseases with asthma and symptoms	53,573	49,500	1,100	2,000	948	25
Diseases of the digestive system and symptoms	95,743	88,156	2,115	3,529	1,921	22
Diseases of the genitourinary system and symptoms	47,711	45,001	417	932	1,351	10
Diseases of skin and cellular tissue	20,899	19,994	373	162	367	3
Diseases of bones and organs of movement and symptoms	39,579	37,721	628	207	1,015	8
Accidents, poisonings, and violence	48,173	44,036	1,235	646	2,234	22
All others	70,251	65,681	1,203	1,653	1,692	22
Unavailable[2]	6,790	5,799	367	471	146	7

[1] *Patient treatment file. This table, as well as all others in this hospital discharge series, excludes approximately 224,590 one-day dialysis discharges.*

[2] *This column/line includes all records for which required data is unavailable.*

VA Medical Centers—Hospital Care Component: Patients Discharged, Age, Diagnostic Category[1]—Fiscal Year 1979

Diagnostic Category and ICDA Codes[2]	Total Diagnoses	Principal Diagnosis[3]	Associated Diagnoses[4]	Average Age	Age Group of Principal Diagnosis							
					Under 35	35-44	45-54	55-64	65-74	75-84	85 and Over	Unavailable[5]
All diseases and conditions	2,149,157	926,775	1,222,382	54.6	134,323	75,432	195,807	309,598	128,976	55,449	26,881	529
I. Infective and parasitic diseases	37,495	13,154	24,341	52.2	2,835	1,048	2,714	3,771	1,541	777	459	9
Pulmonary tuberculosis (011)	4,817	2,602	2,215	55.6	122	211	831	998	294	89	54	3
Tuberculosis, late effects (019)	483	108	375	60.3	4	2	25	46	14	13	4	....
Tuberculosis, other (010, 012-018)	3,260	860	2,400	59.1	74	49	183	282	131	84	57	....
Cardiovascular syphilis (093)	71	13	58	([6])	....	....	1	....	8	3	1	....
Syphilis of central nervous system (094)	237	99	138	([6])	2	1	23	34	24	11	4	....
Other forms of late syphilis, latent, or unspecified (095-097)	2,459	123	2,336	54.7	21	8	24	35	23	9	3	....
All other venereal diseases (090-092, 098-099)	1,853	860	993	35.3	547	99	98	90	21	3	1	1
Infectious hepatitis (070)	745	522	223	35.0	343	52	54	53	18	1	1	....
Malaria (084)	28	14	14	([6])	9	2	1	1	1	....	....	....
All other infective and parasitic diseases (000-009, 020-027, 030-039, 040-046, 050-057, 060-068, 071-079, 080-083, 085-089, 100-104, 110-117, 120-129, 130-136)	23,542	7,953	15,589	53.1	1,713	624	1,474	2,232	1,007	564	334	5
II. Neoplasms	157,785	94,005	63,780	61.4	3,204	2,775	15,723	39,089	21,234	8,353	3,584	43
Malignancy of buccal cavity and pharynx (140-149)	7,932	6,066	1,866	59.7	40	140	1,489	2,879	1,183	246	85	4
Malignancy of digestive organs and peritoneum (150-159)	14,880	12,138	2,742	63.2	116	261	1,789	5,236	2,985	1,210	537	5
Malignancy of respiratory system (160, 162-163)	26,038	22,133	3,905	61.3	69	405	4,142	10,594	5,254	1,290	371	8
Malignancy of larynx (161)	3,144	2,511	633	60.4	10	58	500	1,245	554	113	30	1
Malignancy of lymphatic & hematopoietic tissue (200-209)	13,094	9,476	3,618	58.1	852	506	1,701	3,568	1,833	737	277	2
Malignancy of genito-urinary organs (180-189)	21,743	15,663	6,080	66.8	349	178	1,242	5,371	4,447	2,767	1,303	6
Malignancies of all other systems (170-174, 190-199)	49,311	14,521	34,790	60.8	653	560	2,571	5,760	3,012	1,275	677	13
Neoplasms, benign (210-228)	17,425	9,301	8,124	56.3	977	554	1,917	3,590	1,547	513	199	4
Neoplasms, of unspecified nature (230-239)	4,218	2,196	2,022	60.0	138	113	372	847	419	202	105	....
III. Endocrine, nutritional, and metabolic diseases	121,072	28,371	92,701	57.0	1,589	2,028	7,053	11,435	4,247	1,422	581	16
Diabetes mellitus (250)	72,444	20,712	51,732	57.5	911	1,353	5,210	8,626	3,170	1,040	389	13
Diseases of thyroid and other endocrine glands (240-246, 251-258)	8,976	3,016	5,960	54.0	394	275	682	1,088	392	127	57	1
Avitaminosis and other nutritional deficiency (260-269)	6,396	1,027	5,369	60.9	38	50	227	351	196	101	63	1
Obesity not specified as of endocrine origin (277)	16,771	1,269	15,502	52.6	89	170	401	481	105	18	4	1
Other metabolic diseases (270-276, 278-279)	16,485	2,347	14,138	57.3	157	178	533	889	384	136	68	2
IV. Diseases of blood and blood-forming organs	41,636	5,170	36,466	60.4	488	248	829	1,692	892	666	353	2
Anemia, iron deficiency (280)	9,597	1,266	8,331	64.5	27	34	172	492	246	190	105	....
Pernicious anemia (281.0)	657	193	464	68.0	4	3	15	60	43	44	24	....
Anemia, other (281.1-285)	22,848	2,500	20,348	60.3	284	134	374	729	441	346	190	2
All other diseases of blood and blood-forming organs (286-289)	8,534	1,211	7,323	55.0	173	77	268	411	162	86	34	....
V. Mental disorders	321,364	212,556	108,808	45.2	67,163	31,658	52,105	45,067	10,669	3,623	2,121	150
Alcoholic psychosis (291)	7,963	5,237	2,726	52.6	517	663	1,676	1,778	533	48	14	8
Psychosis associated with drug dependence (294.34)	277	236	41	27.8	207	20	5	3	....	....	....	1
Psychosis associated with organic brain syndrome, excluding alcohol and drug dependence (290, 292-294.30, 294.39-294.9)	7,883	4,699	3,184	63.4	527	140	487	1,105	964	918	607	1
Psychosis not attributed to physical conditions (295-298)	80,950	68,352	12,598	40.0	32,168	18,474	12,960	8,895	2,037	518	278	65
Alcoholism (303)	129,316	87,347	41,969	48.1	14,756	14,869	29,127	23,778	4,162	346	144	50

Non-psychotic organic brain syndrome associated with alcoholism (309.13)	2,288	1,384	904	57.3	54	80	349	606	241	41	10	1
Drug dependence (304)	17,936	8,835	9,101	31.7	8,805	1,056	653	259	25	10	18	10
Non-psychotic organic brain syndrome associated with drug dependence (309.14)	160	105	55	44.1	44	8	18	23	9	3	....	....
Non-psychotic organic brain syndrome associated with other physical conditions (309.0, 309.2-309.9)	16,320	6,788	9,532	67.1	355	249	754	1,582	1,380	1,473	1,033	2
Mental retardation (310-315)	381	106	275	40.7	53	12	12	23	8	....	....	....
All other non-psychotic mental disorders (Y00.1, Y03.4, 300-302, 305-307, 316, 318, 793.0)	57,880	29,457	28,423	42.8	11,878	3,881	6,051	6,013	1,342	270	117	15
VI. Diseases of nervous system & sense organs	108,639	43,997	64,642	56.8	4,606	3,323	8,889	18,614	7,300	3,294	1,308	22
Inflammatory diseases of central nervous system (320-324)	1,103	530	573	49.8	102	62	141	174	35	13	2	1
Epilepsy (345)	7,757	2,940	4,817	47.4	749	440	898	750	228	59	25	2
Amyotrophic lateral sclerosis (348.0)	567	423	144	58.0	11	17	87	235	87	14	2	....
Paraplegia, cerebral or spinal (344.2, 349.3)	4,874	1,730	3,144	44.9	510	292	412	406	76	20	3	2
Quadriplegia, cerebral or spinal (344.3, 349.4)	3,351	1,457	1,894	42.7	580	282	316	297	53	7	2	....
Other diseases of central nervous system, including hereditary and familial disease of nervous system (330-333, 340-344.1, 344.9, 346-347, 349.1-349.2, 349.5-349.9)	23,166	8,055	15,111	56.0	859	642	1,823	3,034	1,422	637	230	8
Diseases of nerves and peripheral ganglia (350-358)	14,420	5,522	8,898	54.4	800	453	1,386	2,124	608	225	55	1
Inflammatory diseases of the eye and other diseases and conditions of the eye, except blindness, (360-369, 370-378)	37,291	17,843	19,448	63.0	572	501	2,601	6,804	4,116	2,206	837	8
Blindness (379)	2,955	788	2,167	67.2	64	52	187	288	114	62	21	....
Diseases of ear and mastoid process (380-389)	12,355	4,079	8,276	62.7	981	402	839	1,532	470	121	32	2
VII. Diseases of the circulatory system	381,065	141,322	239,743	60.9	3,380	5,003	28,898	58,703	25,902	12,674	6,329	52
Chronic rheumatic heart disease (393-398)	9,842	3,863	5,979	57.8	151	242	931	1,858	630	172	70	....
Hypertensive heart disease, exclusive of ischemic heart disease (400.1, 402, 404)	6,190	3,505	2,685	61.2	36	130	880	1,545	684	281	122	1
Hypertensive disease without heart involvement (400.0, 400.2, 400.3, 400.9, 401, 403)	54,970	10,135	44,835	66.0	558	745	2,728	4,263	1,339	368	120	5
Acute myocardial infarction (410)	11,490	8,573	2,917	60.5	70	264	1,964	3,890	1,501	673	300	2
Chronic ischemic heart disease (412)	88,600	39,769	48,831	61.3	290	1,407	8,850	17,102	8,840	3,986	1,902	12
Other ischemic heart disease, with or without hypertensive disease (411, 413, 414)	21,372	6,859	14,513	58.6	49	313	1,896	3,164	968	342	135	2
Other forms of heart disease (391, 392.0, 420-429)	84,790	21,902	62,888	63.4	563	757	3,549	8,046	4,497	2,826	1,063	12
Cerebral hemorrhage (431)	1,292	868	424	60.8	23	29	208	332	143	90	42	1
Cerebral thrombosis (433)	4,244	2,712	1,532	63.8	17	43	396	1,187	625	331	129	1
Cerebral embolism (434)	240	115	125	63.1	3	4	22	48	22	8	10	....
Generalized ischemic cerebrovascular disease (437)	3,738	1,173	2,565	68.6	4	8	113	382	270	264	132	....
All other cerebrovascular disease (430, 432, 435, 436, 438)	25,731	13,201	12,530	64.1	98	212	1,836	5,560	3,229	1,587	660	5
Arteriosclerosis (440)	10,401	3,616	6,785	64.5	4	70	511	1,514	837	444	244	2
All other diseases of arteries, arterioles and capillaries (441-448)	29,812	11,410	18,402	62.2	194	275	1,802	5,033	2,874	975	450	1
Varicose veins lower extremities (454)	5,256	2,247	3,009	57.7	105	142	511	885	328	197	61	....
Hemorrhoids (455)	9,157	4,173	4,984	50.8	660	560	1,126	1,320	362	98	45	2
All other diseases of veins and lymphatics, and other diseases of circulatory system (390, 392.9, 450-453, 456-458)	20,441	7,701	12,740	57.3	557	516	1,754	2,997	1,108	493	221	7
VIII. Diseases of the respiratory system	163,041	58,057	104,984	59.9	4,034	2,440	8,727	22,055	11,544	5,380	2,363	26
Acute respiratory infections including influenza (460-466, 470-474)	8,231	3,125	5,106	54.5	504	187	545	871	471	250	106	1
Pneumonia (480-486)	26,606	11,643	14,963	63.2	684	530	1,805	3,471	2,083	1,770	1,191	3
Bronchitis, unqualified and chronic (490-491)	21,963	6,119	15,844	62.1	100	143	1,025	2,702	1,379	687	179	4
Emphysema (492)	46,886	13,869	33,017	63.5	54	163	1,749	6,480	3,679	1,356	403	5
Asthma (493)	6,475	3,036	3,439	53.3	388	269	768	1,149	358	86	27	1
All other diseases of upper respiratory tract and respiratory system (500-508, 510-519)	52,877	20,262	32,615	58.8	2,216	1,148	3,737	7,802	3,577	1,313	467	12

See footnotes at end of table.

TABLE 27--Continued

VA Medical Centers—Hospital Care Component: Patients Discharged, Age, Diagnostic Category[1]—Fiscal Year 1979—Continued

Diagnostic Category and ICDA Codes[2]	Total Diagnoses	Principal Diagnosis[3]	Associated Diagnoses[4]	Average Age	Age Group of Principal Diagnosis							
					Under 35	35-44	45-54	55-64	65-74	75-84	85 and Over	Unavailable[5]
IX. Diseases of the digestive system	230,522	85,514	145,008	55.3	9,145	6,925	20,256	30,952	11,701	4,480	2,030	46
Diseases of oral cavity, salivary glands, and jaws (520-529)	67,928	5,111	62,817	49.6	1,231	442	1,061	1,857	509	126	52	3
Ulcers digestive system (stomach, duodenum, peptic, gastrojejunal) (531-534)	17,793	9,383	8,410	56.1	823	699	2,186	3,664	1,350	457	199	5
All other diseases esophagus, stomach, and duodenum (except ulcers) (530, 535-537)	20,123	7,886	12,237	58.5	651	629	1,754	3,012	1,202	444	182	2
Hernia of abdominal cavity (550-553)	32,843	19,675	13,168	57.6	1,715	1,121	3,993	7,539	3,456	1,312	529	10
Other diseases of intestine and peritoneum (540-543, 560-569)	42,814	20,240	22,574	55.7	2,684	1,556	4,252	6,674	2,755	1,630	762	17
Alcoholic cirrhosis of liver (571.0)	21,004	9,511	11,493	53.6	425	1,003	3,380	3,777	835	66	21	4
Other diseases of liver, gallbladder and pancreas (570, 571.8, 571.9, 572-577)	28,017	13,708	14,309	53.6	1,606	1,476	3,498	4,629	1,594	625	275	5
X. Diseases of the genitourinary system	113,885	43,087	70,798	59.9	3,611	2,130	6,817	15,712	8,762	4,123	2,018	24
Nephritis and nephrosis (580-584)	11,136	5,096	6,040	55.2	460	427	1,202	1,857	752	203	109	6
Other diseases of urinary system (590-599)	59,644	16,810	42,834	58.6	1,450	1,006	2,987	5,622	2,945	1,803	1,006	9
Diseases of the prostate (600-602)	28,940	13,951	14,989	66.5	172	151	1,149	5,703	4,182	1,816	777	2
Other diseases of male genital organs (603-607)	11,572	5,772	5,800	53.0	1,024	418	1,157	2,107	718	236	109	8
Diseases of breast, gynecological conditions (610-618, 620-629)	2,593	1,458	1,135	49.1	406	126	262	423	157	66	18	1
XI. Deliveries and complications of pregnancy, childbirth and the puerperium (630-678)	73	47	26	(6)	43	3	....	1	....	....	....	....
XII. Diseases of skin and subcutaneous tissue	54,591	20,899	33,692	52.4	3,828	1,847	4,668	6,539	2,389	871	538	19
Infections of skin and subcutaneous tissue (680-686, 694-698)	20,933	9,742	11,191	51.2	1,889	917	2,253	3,008	947	293	224	11
All other diseases of skin and subcutaneous tissue (690-693, 700-709)	33,658	11,157	22,501	53.4	1,939	930	2,415	3,531	1,442	578	314	8
XIII. Diseases of the musculoskeletal system and connective tissue	89,279	37,844	51,435	52.7	5,960	3,491	8,742	13,106	4,477	1,409	548	21
Arthritis and rheumatism, except rheumatic fever (710-718)	41,708	13,846	27,862	58.3	703	729	2,801	5,963	2,314	817	324	5
Displacement of intervertebral disc (725)	3,987	2,830	1,157	48.4	496	482	873	774	161	37	5	2
Osteomyelitis and other diseases of bone and joint (720-724, 726-729)	27,132	13,634	13,498	48.5	3,383	1,639	3,166	3,850	1,070	349	149	8
Other diseases of musculoskeletal system (730-738)	16,452	7,534	8,918	51.8	1,378	641	1,692	2,611	932	206	68	6
XIV. Congenital deformities (741-759)	8,094	2,992	5,102	51.3	547	318	657	1,020	329	82	38	1
XVI.A Symptoms and ill-defined conditions	142,288	51,132	91,156	55.6	6,108	4,131	11,847	17,423	6,734	3,332	1,831	26
Senility without mention of psychosis (794)	736	173	563	82.8	1	....	....	7	17	68	80	....
Symptoms and all other ill-defined conditions (780-792, 795-796)	141,552	50,959	90,593	55.5	6,107	4,131	11,847	17,416	6,717	3,264	1,751	26
XVI.B Observation and examination cases, follow-up and special admissions	63,280	28,327	34,953	57.6	2,541	1,579	5,587	10,762	5,115	1,950	781	12
Tuberculosis (Y03.01, Y03.2, Y10.61-Y10.63)	2,455	311	2,144	58.6	4	15	91	128	52	16	5	....
Malignancy (793.1, Y03.3)	16,183	8,618	7,565	62.7	157	218	1,342	3,584	2,094	862	361	2
All other admissions (793.8, 793.9, Y00.0, Y00.01, Y00.09, Y00.2-Y01, Y03.02, Y03.91-Y03.94, Y04-Y06, Y10.0-Y10.6, Y10.08, Y10.64-Y10.69, Y10.9, Y11-Y12, Y20-Y29)	44,339	19,108	25,231	55.6	2,216	1,306	4,112	7,050	2,962	1,041	411	10
Diagnosis deferred, mental observation (318.0, APA Code)	303	290	13	37.0	164	42	42	33	7	1	1	....

XVII. Accidents, poisonings, and nature of injury	107,758	53,011	54,747	49.8	14,130	5,045	10,586	13,782	5,198	2,642	1,577	52
Fracture of skull and facial bones (800-804)	3,269	2,157	1,112	42.3	910	270	425	397	87	40	22	8
Fracture of skull and facial bones, late effects (800-804)[7]	672	370	302	40.9	159	59	74	58	16	2	2	....
Fracture of spine and trunk (805-809)	5,518	2,715	2,803	54.3	489	204	555	874	327	174	120	2
Fracture of spine and trunk, late effects (805-809)[7]	5,161	1,097	4,064	45.6	334	158	284	227	59	22	12	1
Fracture of upper limb (810-819)	5,416	3,149	2,267	49.6	877	263	582	853	348	127	79	2
Fracture of upper limb, late effects (810-819)[7]	1,289	741	548	43.4	303	78	145	136	62	12	6	1
Fracture of lower limb (820-829)	11,177	8,325	2,852	57.1	1,229	608	1,523	2,369	1,153	852	586	4
Fracture of lower limb, late effects (820-829)[7]	2,854	1,748	1,106	48.4	531	179	329	426	132	81	58	2
Dislocation without fracture (830-839)	2,090	1,504	586	41.4	705	149	345	294	78	21	13	1
Dislocation without fracture, late effects (830-839)[7]	549	402	147	38.7	216	40	71	59	11	3	2	....
Intracranial injury—without skull fracture (850-854)	3,323	2,280	1,043	47.4	729	243	426	817	209	106	48	5
Intracranial injury—without skull fracture, late effects (850-854)[7]	1,763	822	941	44.1	322	89	172	163	43	18	13	2
Internal injury of chest, abdomen and pelvis (860-869)	1,248	580	668	47.1	169	68	136	138	46	12	12	1
Internal injury of chest, abdomen and pelvis, late effects (860-869)[7]	141	61	80	([6])	22	4	10	20	3	1	1	....
Traumatic amputation of arm and hand—complete/partial (887)	14	8	6	([6])	2	1	4	1	....	....	....	....
Traumatic amputation of arm and hand—complete/partial, late effects (887)[7]	21	12	9	([6])	9	1	1	1	....	....	....	....
Traumatic amputation of foot and leg(s)—complete/partial (896-897)	87	32	55	([6])	11	2	4	10	3	1	1	....
Traumatic amputation of foot and leg(s)—complete/partial, late effects (896-897)[7]	99	38	61	([6])	9	6	6	9	5	3	....	....
Burns (940-949)	2,169	1,253	916	50.4	269	120	304	367	134	37	20	2
Burns, late effects (940-949)[7]	284	167	117	50.1	41	19	34	47	18	6	3	....
Injury to nerves and spinal cord (950-959)	710	325	385	43.0	130	37	78	55	19	6	3	....
Injury to nerves and spinal cord, late effects (950-959)[7]	1,113	485	628	44.9	153	70	128	108	23	4	....	1
Adverse effect of medicinal agents and other complications of surgical and medical care (960-979, 997-999)	30,681	10,919	19,762	53.9	1,906	881	2,197	3,454	1,414	687	369	11
All other accidents, poisonings and violence (840-848, 870-879, 880-886, 890-895, 900-907, 910-918, 920-929, 930-939, 980-996)	26,288	12,887	13,401	46.3	4,296	1,294	2,840	2,977	967	405	198	10
All other accidents, poisonings and violence, late effects (870-879, 880-886, 890-895, 900-907, 910-918, 920-929)[7]	1,822	934	888	44.2	380	104	217	192	49	14	7	1
Unavailable[5]	6,790	6,790	....	54.1	1,122	532	1,330	2,313	952	333	203	5

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[1] *Patient treatment file. This table as well as all others in this discharge series, excludes approximately 224,590 one-day dialysis discharges.*

[2] *The diagnostic categories and selected diagnoses included in this table are based on the "International Classification of Diseases Adapted for Indexing of Hospital Records", USPHS Publication No. 1693. The numbers following the diagnoses are the identifying code numbers of this diagnostic classification. Category XV, "Certain Causes of Perinatal Morbidity and Mortality", in which no cases occurred, is not included in this table.*

[3] *Principal diagnosis is that diagnosis designated by the discharge physician as responsible for the major portion of the patients length of stay.*

[4] *Associated diagnoses are established diagnoses for which treatment was given, other than the principal diagnosis.*

[5] *This column/line includes all records for which required data is unavailable.*

[6] *Average age not calculated for totals of less than 100 cases.*

[7] *All late effect codes are differentiated from other codes by being uniformly .9 in the fourth digit position.*

TABLE 28

VA Medical Centers—Hospital Care Component: Patients Discharged, Type of Patient, Age, Length of Stay[1]—Fiscal Year 1979

Type of Patient and Age Group	Total Patients	Average Days	Median Days[2]	Length of Stay Distribution (Days)														Total days[4]
				1 Day	2-3	4-7	8-14	15-21	22-30	31-60	61-90	91-180	181-270	271-365	366-730	731 Plus	Unavailable[3]	
All patients	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Under 20	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
20-24	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
25-29	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
30-34	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
35-39	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
40-44	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
45-49	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
50-54	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
55-59	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
60-64	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
65-69	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
70-74	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
75-79	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
80-84	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
85 and over	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Unavailable[3]	[illegible]	Not computed		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Tuberculosis	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Under 20	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
20-24	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
25-29	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
30-34	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
35-39	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
40-44	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
45-49	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
50-54	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
55-59	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
60-64	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
65-69	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
70-74	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
75-79	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
80-84	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
85 and over	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Unavailable[3]	[illegible]	Not computed		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Psychosis	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Under 20	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
20-24	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
25-29	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
30-34	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
35-39	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
40-44	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
45-49	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
50-54	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
55-59	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
60-64	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
65-69	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
70-74	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
75-79	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
80-84	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
85 and over	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Unavailable[3]	[illegible]	Not computed		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Other psychiatric	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Under 20	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
20-24	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
25-29	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

30-34	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
35-39	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
40-44	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
45-49	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
50-54	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
55-59	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
60-64	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
65-69	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
70-74	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
75-79	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
80-84	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
85 and over	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Unavailable[3]	[illegible]	Not computed		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Neurological	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Under 20	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
20-24	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
25-29	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
30-34	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
35-39	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
40-44	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
45-49	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
50-54	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
55-59	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
60-64	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
65-69	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
70-74	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
75-79	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
80-84	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
85 and over	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Unavailable[3]	[illegible]	Not computed		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
General medical and surgical	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Under 20	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
20-24	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
25-29	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
30-34	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
35-39	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
40-44	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
45-49	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
50-54	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
55-59	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
60-64	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
65-69	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
70-74	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
75-79	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
80-84	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
85 and over	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Unavailable[3]	[illegible]	Not computed		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Unavailable[3]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Under 20	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
20-24	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
25-29	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
30-34	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
35-39	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
40-44	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
45-49	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
50-54	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
55-59	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
60-64	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
65-69	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
70-74	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
75-79	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
80-84	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
85 and over	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Unavailable[3]	[illegible]	Not computed		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

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[1] Patient treatment file. This table, as well as all others in this hospital discharge series, excludes approximately 224,590 one-day dialysis discharges.

[2] One-half of the discharges in the given category have length of stay greater than the median, the other half, less than the median.

[3] This column/line includes all records for which required data is unavailable.

[4] This column excludes those cases for which the number of days is unavailable.

VA Medical Centers—Hospital Care Component: Patients Discharged, Age, Marital Status, Diagnostic Grouping¹—Fiscal Year 1979

Diagnostic Composition of Patients	Total Discharged	Age Group						Marital Status					
		Under 45	45-54	55-64	65-74	75 and Over	Unavailable²	Never Married	Married	Separated	Widowed	Divorced	Unknown²
All discharges	926,776	209,756	186,807	309,699	128,876	82,110	529	136,851	502,577	48,351	58,076	156,023	25,706
Tuberculosis	3,829	469	1,117	1,439	460	321	3	611	1,589	323	320	867	126
Pulmonary tuberculosis	2,602	333	831	998	294	143	3	435	947	260	221	646	83
Other tuberculosis	1,227	136	296	441	166	178	......	176	639	63	95	211	43
Psychoses	78,524	44,716	16,161	12,761	3,024	2,380	72	33,179	21,704	5,071	2,980	13,750	2,860
Other psychiatric	134,032	54,115	36,904	32,358	7,145	3,464	76	24,523	60,965	11,739	6,258	37,720	2,830
Neurological	58,146	11,753	12,035	20,063	8,782	5,477	36	7,049	34,611	2,882	3,076	8,471	1,767
Vascular lesions affecting central nervous system	18,989	439	2,570	7,468	4,268	3,259	7	1,394	11,506	674	1,880	2,248	571
Other neurological	38,196	11,148	9,252	12,212	4,395	2,173	28	5,572	22,491	1,988	1,958	6,121	1,166
Neurological diseases of the sense organs	950	166	208	383	109	45	......	83	616	30	37	104	20
General medical and surgical	646,405	97,048	129,220	240,726	108,093	70,032	328	70,494	380,270	38,153	48,426	93,239	17,869
Infective and parasitic diseases	9,258	3,326	1,578	2,371	1,085	814	8	1,627	5,150	436	516	1,238	271
Malignant neoplasms	81,703	4,050	13,261	34,329	19,155	10,003	38	7,446	51,730	3,017	6,584	10,787	2,142
Benign and unspecified neoplasms	10,611	1,809	2,111	4,095	1,837	952	4	1,107	6,980	367	632	1,499	239
Allergic and endocrine system	27,525	3,007	6,838	11,276	4,188	1,896	16	3,026	17,101	1,329	1,837	3,889	742
Heart disease and symptoms	86,679	4,435	18,042	35,446	15,888	12,119	29	5,836	57,309	2,839	8,636	10,161	2,308
Vascular diseases	38,216	4,444	8,410	16,969	8,674	3,702	17	3,945	23,771	1,729	2,958	5,868	940
Acute respiratory diseases	15,733	2,090	2,866	4,628	2,716	3,431	6	1,887	8,553	807	1,893	2,301	492
Other respiratory diseases with asthma and symptoms	53,573	6,136	10,283	22,108	10,114	4,896	28	6,024	32,238	2,370	3,834	8,804	1,263
Diseases of the digestive system and symptoms	86,743	18,320	22,383	34,441	13,139	7,409	50	11,271	58,002	4,599	5,910	10,729	2,641
Diseases of the genitourinary system and symptoms	47,711	6,372	7,525	17,236	9,004	6,954	25	5,176	30,040	1,741	3,584	5,352	1,376
Diseases of skin and cellular tissue	20,696	5,775	4,089	6,539	2,389	1,806	15	3,334	11,166	1,136	1,166	3,486	686
Diseases of bones and organs of movement and symptoms	38,579	9,951	9,086	13,702	4,068	2,080	24	4,126	28,636	1,085	1,881	6,457	614
Accidents, poisonings and violence	48,173	16,560	9,544	12,716	4,871	4,506	43	8,737	22,587	2,794	2,999	9,285	1,771
All others	78,251	10,042	12,723	25,603	13,677	9,174	32	7,634	42,095	2,689	5,278	8,308	2,210
Unavailable²	8,790	1,864	1,330	2,313	952	536	5	1,166	3,363	387	413	977	536

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[1] *Patient treatment file. This table, as well as all others in this hospital discharge series, excludes approximately 224,590 one-day dialysis discharges.*

[2] *This column/line includes all records for which required data is unavailable.*

VA Medical Centers—Hospital Care Component: Patients Discharged, Compensation and Pension Status, Type of Patient, Age[1]—Fiscal Year 1979

Type of Patient and Age Group	Total All Patients	Service-Connected Veterans				Non-Service-Connected			Non-Veterans[3]	Un-available[4]
		Total	10% or more	Less Than 10%	NSC with SC[2]	Total	Pension	Other		
All patients	925,775	261,730	[illegible]	3,461	152,087	652,530	190,331	460,209	6,090	5,225
Under 25	27,655	6,613	4,677	119	1,817	18,457	572	17,885	2,340	245
25-34	107,060	37,630	23,995	353	13,282	67,034	4,706	62,328	1,585	810
35-44	75,432	20,743	11,580	172	8,991	53,479	4,764	48,715	710	500
45-54	195,907	47,380	18,980	460	27,940	146,636	36,945	109,691	650	1,243
55-64	309,598	90,627	26,043	854	63,730	216,296	70,842	145,454	549	2,126
65 and over	210,978	48,854	11,043	497	37,314	160,380	78,443	81,937	454	1,290
Unavailable[4]	525	153	77	1	75	342	53	289	30	2
Tuberculosis	3,839	796	273	9	514	2,935	811	2,124	8	5
Under 25	26	3	2	0	1	22	0	22	1	0
25-34	171	40	18	2	20	131	7	124	0	0
35-44	272	35	16	2	17	235	18	217	2	0
45-54	1,117	186	73	1	112	929	226	703	2	0
55-64	1,430	350	117	3	230	1,088	341	747	2	0
65 and over	851	171	48	1	122	638	319	319	1	0
Unavailable[4]	3	1	1	0	0	2	0	2	0	0
Psychotic	78,534	36,606	30,973	331	5,602	40,770	11,102	29,668	812	30
Under 25	7,373	3,201	2,934	30	237	2,436	131	2,305	630	6
25-34	26,146	14,747	13,160	108	1,479	11,173	1,538	9,635	217	9
35-44	11,297	5,251	4,605	42	614	5,990	927	5,063	42	4
45-54	15,141	6,058	4,941	67	1,050	9,580	3,680	5,901	10	4
55-64	12,781	5,734	4,226	66	1,443	7,051	2,918	4,133	4	3
65 and over	5,904	1,773	1,083	23	664	4,016	1,895	2,131	14	1
Unavailable[4]	73	32	26	0	6	36	5	30	5	0
Other Psychiatric	134,032	29,714	11,542	320	17,857	103,462	19,395	84,067	751	25
Under 25	5,895	780	447	11	322	4,631	97	4,534	371	5
25-34	28,049	6,567	3,073	42	3,452	21,251	926	20,325	209	2
35-44	20,371	3,571	1,406	41	2,124	16,722	987	15,735	74	4
45-54	36,964	7,132	2,438	82	4,612	29,780	6,862	23,918	47	5
55-64	32,398	9,246	3,373	90	5,775	22,916	7,331	15,585	36	6
65 and over	10,699	2,432	801	29	1,602	8,152	4,178	3,964	14	1
Unavailable[4]	78	18	5	1	12	60	4	56	0	0
Neurological	58,145	10,290	6,272	132	3,236	41,912	13,110	28,802	625	15
Under 25	1,449	346	259	3	84	834	44	790	268	1
25-34	5,796	2,091	1,348	25	723	3,495	582	2,913	148	2
35-44	4,590	1,460	926	15	529	3,071	376	2,695	61	1
45-54	12,636	2,901	1,362	22	1,507	8,970	2,591	6,379	74	0
55-64	20,063	5,661	1,631	47	3,983	14,363	4,540	9,823	33	6
65 and over	14,250	3,039	662	30	2,396	11,166	4,054	6,132	40	5
Unavailable[4]	35	8	4	0	4	23	3	20	4	0
General medical and surgical	645,455	166,573	47,483	1,661	118,396	473,909	161,678	321,231	3,777	196
Under 25	12,966	2,370	1,342	75	953	9,516	279	9,319	1,967	11
25-34	45,720	13,629	6,361	187	7,685	30,961	1,732	29,229	811	20
35-44	38,382	10,391	4,608	78	5,705	27,427	2,404	24,973	531	13
45-54	129,228	30,900	10,152	308	20,440	97,780	24,552	73,228	486	45
55-64	240,725	69,046	16,677	643	52,246	170,631	55,652	114,979	475	54
65 and over	178,125	41,417	8,615	611	32,096	136,272	66,948	69,324	364	52
Unavailable[4]	330	52	42	6	55	250	41	179	23	1
Unavailable[4]	8,780	251	91	3	108	527	145	377	4	8,063
Under 25	260	5	3	0	2	16	1	15	3	337
25-34	675	37	26	3	8	53	1	52	0	706
35-44	532	25	15	0	10	34	2	32	0	473
45-54	1,330	32	15	0	17	108	26	82	1	1,189
55-64	2,213	79	27	9	43	187	60	127	0	2,056
65 and over	1,480	36	9	0	26	122	55	67	0	1,331
Unavailable[4]	5	2	1	0	1	2	0	3	0	1

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[1] Patient treatment file. This table as well as all others in this hospital discharge series excludes approximately 224,500 one-day dialysis discharges.

[2] Veterans with compensable service-connected disabilities but treated for non-service connected disabilities only.

[3] This group includes all patients other than veterans, such as active military, humanitarian emergencies, reimbursable cases, allied beneficiaries, donors, etc. If a veteran is admitted as an Office of Workers Compensation Program case, he is coded as a non-veteran.

[4] This column/line includes all records for which required data is unavailable.

VA Medical Centers-Hospital Care Component: Patients Discharged, Compensation and Pension Status, Type of Patient, Sex[1]—Fiscal Year 1979

Compensation and Pension Status	All Patients							Female[4]							Male[4]						
	Total	Tuberculous	Psychotic	Other Psychiatric	Neurological	GM&S	Unavailable[2]	Total	Tuberculous	Psychotic	Other Psychiatric	Neurological	GM&S	Unavailable[2]	Total	Tuberculous	Psychotic	Other Psychiatric	Neurological	GM&S	Unavailable[2]
VA hospitals—total . . .	926,775	3,829	78,524	134,032	58,145	645,455	6,790	15,454	17	1,936	1,685	1,010	10,674	132	911,205	3,821	76,584	132,330	57,128	634,719	6,656
Service-connected	99,073	281	31,304	11,867	6,354	49,174	93	1,930	2	682	295	116	833	2	97,127	279	30,619	11,571	6,238	48,330	90
10% or more	96,592	272	30,973	11,542	6,222	47,492	91	1,865	2	670	285	111	795	2	94,711	270	30,300	11,256	6,111	46,686	88
Less than 10%	2,481	9	331	325	132	1,682	2	65	0	12	10	5	38	0	2,416	9	319	315	127	1,644	2
Non-service connected with SC	152,657	505	5,502	17,907	9,236	119,390	108	1,998	2	79	177	123	1,614	3	150,642	503	5,421	17,726	9,111	117,776	105
NSC with pension	196,331	911	11,102	19,385	13,110	151,678	145	2,805	4	365	218	163	2,054	1	193,508	907	10,738	19,166	12,944	149,611	144
NSC no claim pending	466,280	2,124	29,668	84,087	28,802	321,231	377	7,526	8	759	923	470	5,355	11	458,709	2,116	28,909	83,163	28,328	315,828	365
Non-veterans[3]	6,090	8	922	751	629	3,777	4	1,070	1	51	72	137	808	1	5,019	7	871	679	491	2,988	3
Unavailable[2]	6,325	0	26	25	16	196	6,063	125	0	0	0	1	10	114	6,200	0	26	25	14	186	5,949

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[1] *Patient treatment file. This table as well as all others in this hospital discharge series, excludes approximately 224,590 one-day dialysis discharges.*

[2] *This column/line includes all records for which required data is unavailable.*

[3] *This group includes all patients other than veterans, such as active military, humanitarian emergencies, reimbursable cases, allied beneficiaries, donors, etc. If a veteran is admitted as an office of workers compensation program case, he is coded as a non-veteran.*

[4] *The total female and male discharges will not equal the total discharges since 116 records did not have sex data available.*

VA Medical Centers—Hospital Care Component: Patients Discharged, Type of Patient, Percent Hospitalized in Reported State of Residence[1] [3] —Fiscal Year 1979

Reported State of Residence	All Discharges			Type of Patient											
	Total[2]	Hospitalized in Same State		General Medical And Surgical		Tuberculous		Psychotic		Other Psychiatric		Neurological		Unavailable	
		Number	Percent	Total	Percent Hospitalized In Same State	Total	Percent Hospitalized In Same State	Total	Percent Hospitalized In Same State	Total	Percent Hospitalized In Same State	Total	Percent Hospitalized In Same State	Total	Percent Hospitalized In Same State
Total	926,561	812,274	87.7	640,311	88.2	3,827	88.5	78,500	88.2	134,004	85.6	58,130	85.0	6,789	89.0
United States	915,559	801,635	87.6	639,017	88.1	3,789	88.4	75,918	87.9	133,486	85.6	57,596	85.8	6,754	88.9
Alabama	21,643	19,479	90.0	13,850	90.9	129	90.3	2,305	86.3	4,239	89.2	1,288	87.1	33	66.7
Alaska	179	....	0.0	119	0.0	....	0.0	16	0.0	29	0.0	16	0.0	....	0.0
Arizona	17,939	17,291	96.4	13,330	97.0	92	96.8	1,157	94.6	2,153	94.7	1,171	95.0	37	91.9
Arkansas	19,725	16,218	82.2	14,865	82.2	70	85.7	751	95.5	2,866	87.9	1,148	77.4	196	7.1
California	80,362	78,388	97.6	57,557	97.8	244	98.0	7,239	98.6	9,912	96.4	5,042	98.1	288	97.2
Colorado	10,098	9,270	91.8	6,741	93.3	13	92.3	851	91.8	1,890	87.8	587	86.7	98	95.9
Connecticut	7,817	7,201	92.6	5,623	96.4	27	96.3	675	68.4	868	82.1	606	93.3	18	72.2
Delaware	2,323	2,028	87.3	1,764	98.5	15	80.0	118	35.6	255	48.3	157	90.4	14	100.0
District of Columbia	4,292	4,065	94.7	3,100	97.1	38	100.0	317	80.1	512	91.6	305	89.8	20	95.0
Florida	48,701	46,292	95.1	37,541	96.5	262	93.1	3,239	89.5	4,533	90.4	3,114	94.6	22	81.8
Georgia	25,381	19,649	77.5	17,824	78.1	169	82.8	1,742	69.6	4,021	78.6	1,582	76.1	42	76.2
Hawaii	60	....	0.0	23	0.0	....	0.0	5	0.0	18	0.0	4	0.0	....	0.0
Idaho	4,728	2,711	57.3	3,555	59.7	11	45.5	227	57.3	580	44.7	355	53.8	....	0.0
Illinois	40,486	33,074	81.7	29,846	79.5	298	89.3	2,700	88.0	6,831	88.9	2,682	70.4	289	85.4
Indiana	16,710	12,638	75.6	11,068	74.5	78	70.5	1,695	79.9	2,781	78.7	1,051	70.9	47	57.4
Iowa	14,950	12,170	81.5	11,319	81.9	55	78.2	1,067	88.4	1,980	78.5	933	78.8	16	50.0
Kansas	12,939	7,201	56.2	8,852	57.0	33	58.5	847	84.5	2,437	48.6	812	50.3	17	5.9
Kentucky	16,181	13,016	78.5	12,761	78.1	72	68.1	1,171	82.2	1,813	77.3	1,229	73.1	135	93.3
Louisiana	20,206	18,579	91.8	15,110	94.9	136	96.3	1,277	69.2	2,540	86.2	1,110	91.4	13	53.8
Maine	5,653	5,273	93.3	3,888	92.4	9	100.0	950	97.8	1,639	98.1	264	86.0	14	85.7
Maryland	12,860	8,674	67.4	8,493	66.1	59	72.9	890	70.4	2,830	72.7	631	63.1	30	26.3
Massachusetts	16,181	15,960	87.9	11,045	84.5	42	76.2	2,350	94.0	3,631	94.4	1,083	87.6	40	95.0
Michigan	24,037	22,860	95.1	16,257	95.7	79	96.7	3,185	95.4	3,983	94.3	1,267	89.2	207	98.6
Minnesota	17,560	14,832	84.5	12,606	83.1	38	73.7	1,331	81.5	2,054	86.1	1,320	85.5	203	99.0
Mississippi	16,326	13,010	79.7	12,231	81.4	91	82.4	1,076	82.3	1,713	81.6	989	80.1	217	6.9
Missouri	28,075	22,732	80.9	20,852	84.2	88	93.2	1,685	81.4	3,744	61.6	1,794	83.2	102	71.6
Montana	6,757	4,945	73.2	5,041	75.7	15	86.7	272	45.5	1,104	67.8	365	70.7	10	70.0
Nebraska	11,270	9,818	87.2	7,917	90.0	14	92.9	609	78.0	2,189	78.8	648	86.3	22	86.4
Nevada	4,518	2,936	64.8	3,412	64.8	16	75.0	236	53.4	573	71.2	287	58.9	12	83.3
New Hampshire	5,657	3,195	56.5	4,361	57.9	14	35.7	201	39.6	735	60.4	340	52.4	6	0.0
New Jersey	15,062	12,312	81.7	8,789	79.2	50	90.0	2,359	88.8	2,850	85.7	868	78.0	216	89.4
New Mexico	6,272	5,657	90.2	4,485	91.5	25	96.0	503	86.1	797	85.4	454	87.4	8	87.5
New York	60,177	58,246	96.8	40,123	96.8	250	97.7	6,243	97.0	9,492	96.9	3,428	96.1	631	96.9
North Carolina	24,092	22,414	93.0	17,018	94.1	130	95.4	1,950	94.6	3,657	89.9	1,559	95.6	8	87.5
North Dakota	2,718	2,060	75.8	1,859	82.4	1	100.0	127	26.8	523	66.5	290	73.0	6	0.0
Ohio	26,529	23,002	86.7	14,829	83.7	85	82.4	3,401	91.2	4,385	89.1	1,512	82.9	2,296	99.3
Oklahoma	14,790	12,899	87.2	11,060	90.4	61	93.4	679	67.5	2,123	76.6	968	86.8	20	90.0
Oregon	13,629	10,720	78.7	10,282	80.2	56	78.6	728	88.4	1,538	63.7	1,016	78.6	22	90.9
Pennsylvania	31,166	28,632	92.6	19,961	91.9	106	87.7	4,025	94.8	4,907	94.4	1,870	89.6	330	93.3
Rhode Island	3,596	3,138	87.3	2,690	90.6	8	75.0	316	73.7	381	74.8	249	89.2	3	0.0
South Carolina	17,413	11,880	68.2	12,756	73.9	57	68.4	1,047	60.3	2,205	35.7	1,288	73.6	20	70.0
South Dakota	7,945	6,918	87.1	5,106	84.9	21	90.5	481	82.3	1,929	94.2	483	77.8	7	42.9
Tennessee	22,301	21,443	96.2	15,440	96.6	94	96.8	1,610	93.9	2,945	94.4	1,571	96.1	634	99.4
Texas	70,876	66,494	93.7	52,184	94.0	332	93.4	5,293	88.9	9,072	91.6	4,087	92.1	109	96.3
Utah	5,697	5,511	96.7	3,833	96.7	7	100.0	416	97.6	1,039	95.8	399	98.2	5	60.0
Vermont	2,352	2,111	89.8	1,821	92.1	10	100.0	106	61.5	276	82.6	137	82.0	5	60.0
Virginia	21,078	17,166	81.4	13,579	80.7	98	84.7	1,849	89.3	3,620	78.0	1,584	85.7	48	79.2
Washington	15,840	15,072	95.2	11,024	95.3	40	35.0	1,260	95.4	2,235	96.3	1,071	93.2	3	66.7
West Virginia	12,804	11,589	90.5	9,917	89.0	38	86.8	711	49.6	2,360	75.4	735	78.6	43	37.2
Wisconsin	18,929	18,129	95.2	12,586	93.1	58	94.8	1,639	88.9	2,950	89.2	1,435	87.7	341	93.5
Wyoming	3,536	2,464	69.7	2,352	64.7	7	85.7	185	77.3	767	85.5	218	62.8	7	14.3
Outside United States	11,002	10,639	96.7	7,294	96.2	39	94.9	2,582	98.6	518	94.8	534	95.7	35	94.3
Canal Zone	2	....	0.0	1	0.0	....	0.0	1	0.0	....	0.0	....	0.0	....	0.0
Guam	4	....	0.0	3	0.0	....	0.0	1	0.0	....	0.0	....	0.0	....	0.0
Philippines, Republic of	....	....	0.0	....	0.0	....	0.0	....	0.0	....	0.0	....	0.0	....	0.0
Puerto Rico	10,685	10,639	99.6	7,060	99.7	37	100.0	2,561	99.5	498	98.6	514	99.4	35	94.3
Others	311	....	0.0	230	0.0	2	0.0	19	0.0	20	0.0	20	0.0	....	0.0

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[1] *Patient treatment file. This table, as well as all others in this hospital discharge series, excludes approximately 224,500 one-day dialysis discharges.*

[2] *This column includes all records for which required data is unavailable.*

[3] *This table excludes 214 cases for which residence data is unavailable.*

TABLE 23

VA Medical Centers—Hospital Care Component: Patients Discharged, Diagnostic Grouping, Average and Median Length of Stay, Length of Stay Distribution[1]—Fiscal Year 1979

Principal Diagnosis[2]	Total Patients	Average Length of Stay	Median Length of Stay[3]	Length of Stay Distribution (Days)														Total Days[2]
				1 Day	2-3	4-7	8-14	15-21	22-30	31-60	61-90	91-180	181-270	271-365	366-730	731 Plus	Unknown[3]	
All diseases and conditions	929,775	29.5	11.0	91,677	134,885	182,294	190,965	108,340	81,449	97,746	37,882	21,389	5,316	2,317	3,549	3,227	90	27,382,541
I. Infective and parasitic diseases	12,154	27.0	10.0	1,018	1,956	2,302	2,540	1,479	1,070	1,194	353	380	113	34	41	28	......	364,575
Pulmonary tuberculosis (011)	2,602	51.7	23.5	84	105	194	433	422	374	479	164	222	77	20	20	7	......	134,481
Tuberculosis, late effects (019)	108	28.5	12.7	2	19	19	21	10	11	12	6	6	1	1	......	......	......	3,076
Tuberculosis, other (010, 012-018)	860	30.6	14.0	40	71	116	206	148	95	111	27	33	7	1	5	2	......	26,316
Cardiovascular syphilis (093)	13	15.8	8.0	......	2	4	4	......	......	2	1	......	......	......	......	......	......	206
Syphilis of central nervous system (094)	90	61.5	18.0	17	8	12	11	11	9	15	8	6	......	......	......	2	......	6,090
Other forms of late syphilis, latent, or unspecified (095-097)	123	13.2	6.0	20	37	18	20	8	10	8	1	......	......	1	......	......	......	1,630
All other venereal diseases (090-092, 098-099)	860	7.2	4.2	141	277	228	144	30	23	13	1	......	......	1	2	......	......	6,213
Infectious hepatitis (070)	522	9.7	7.6	39	96	140	102	40	29	17	1	1	......	......	......	......	......	5,095
Malaria (084)	14	5.4	2.5	......	8	4	1	......	1	......	......	......	......	......	......	......	......	75
All other infective and parasitic diseases (000-009, 020-027, 030-039, 040-046, 050-057, 060-068, 071-079, 080-083, 085-089, 100-104, 110-117, 120-129, 130-136)	7,863	21.6	7.6	1,286	1,342	1,867	1,576	604	536	537	144	122	28	10	14	17	......	171,413
II. Neoplasms	96,006	23.5	12.4	12,320	11,927	12,731	15,867	10,802	8,077	13,282	4,256	2,331	320	110	151	67	7	[illegible]
Malignancy of buccal cavity and pharynx (140-149)	6,090	36.2	19.6	453	589	645	898	683	594	1,047	614	433	63	20	22	4	1	219,467
Malignancy of digestive organs and peritoneum (150-159)	12,138	29.2	17.5	1,109	943	1,737	1,756	1,514	1,603	2,362	874	364	90	18	10	11	2	353,946
Malignancy of respiratory system (160, 162-163)	22,133	25.6	16.5	1,949	1,983	2,614	3,904	3,019	2,830	4,082	1,112	505	65	18	38	11	3	567,852
Malignancy of larynx (161)	2,511	35.0	21.2	118	290	245	335	301	286	486	286	140	14	4	4	2	......	87,867
Malignancy of lymphatic and hematopoietic tissue (200-209)	9,476	17.3	8.6	1,732	1,480	1,407	1,678	969	810	997	230	156	20	5	11	6	......	164,404
Malignancy of genitourinary organs (180-189)	15,663	24.1	12.8	1,476	1,873	2,259	3,244	2,090	1,639	2,152	580	310	47	21	18	13	1	377,549
Malignancies of all other systems (170-174, 190-199)	14,521	20.8	9.8	2,730	2,039	1,940	2,291	1,476	1,228	1,732	644	339	49	16	31	11	......	302,224
Neoplasms, benign (210-229)	9,301	10.2	4.0	2,327	2,344	1,514	1,455	659	449	387	78	56	6	4	8	4	......	95,254
Neoplasms, of unspecified nature (230-239)	2,196	17.5	6.8	442	405	365	387	221	149	137	31	30	5	4	4	5	......	38,344
III. Endocrine, nutritional, and metabolic diseases	27,371	23.4	12.1	1,860	2,080	4,752	7,667	3,968	2,084	2,049	783	670	172	70	83	39	......	643,078
Diabetes mellitus (250)	20,712	24.6	12.6	1,336	1,690	3,360	6,098	3,053	1,981	1,981	580	531	130	58	64	34	......	508,444
Diseases of thyroid and other endocrine glands (240-246, 251-258)	3,016	17.7	10.5	280	446	535	787	255	287	282	66	30	10	1	5	3	......	53,519
Avitaminosis and other nutritional deficiency (260-269)	1,027	32.8	17.0	76	78	118	201	150	137	106	47	46	11	6	4	1	......	33,731
Obesity not specified as of endocrine origin (277)	1,289	27.5	12.4	72	126	218	335	162	110	113	41	55	15	5	6	1	......	34,863
Other metabolic diseases (270-276, 278-279)	2,347	13.9	8.4	225	402	522	536	280	169	106	42	15	6	......	4	......	......	32,622
IV. Diseases of blood and blood-forming organs	5,170	20.3	10.1	707	774	709	1,136	732	464	425	88	41	10	4	15	7	......	104,723
Anemia, iron deficiency (280)	1,266	21.2	14.2	87	107	145	337	257	169	127	22	8	2	......	3	2	......	26,850
Pernicious anemia (281.0)	163	32.0	14.5	14	21	15	50	29	27	23	2	......	1	......	......	1	......	6,180

Anemia, other (281.1-285)	2,[illegible]	20.1	7.5	464	430	375	460	276	194	183	41	21	4	4	8	3	.....	[illegible]
All other diseases of blood and blood-forming organs (286-289)	1,211	17.8	9.1	122	298	234	280	180	74	92	21	12	3	.....	4	1	.....	21,[illegible]
V. Mental disorders	212,[illegible]	87.3	16.3	17,[illegible]	23,292	29,[illegible]	32,613	29,[illegible]	23,081	37,236	11,164	9,341	2,687	1,222	1,824	2,025	22	12,167,771
Alcoholic psychosis (291)	5,237	75.9	13.0	460	636	[illegible]	1,023	561	416	613	229	185	78	42	90	115	.....	397,373
Psychosis associated with drug dependence (294.34)	236	27.7	11.6	19	21	45	66	23	20	22	4	12	1	.....	1	1	1	6,598
Psychosis associated with organic brain syndrome, excluding alcohol and drug dependence (290, 292-294.30, 294.39-294.9)	4,[illegible]	238.3	20.6	174	230	373	684	470	438	749	330	426	178	99	210	339	1	1,672,649
Psychosis not attributed to physical conditions (295-298)	68,382	92.2	22.6	6,079	5,111	6,834	9,417	7,299	7,785	12,900	5,027	4,861	1,405	702	940	1,061	12	6,301,054
Alcoholism (303)	87,347	23.2	12.6	6,716	12,782	16,412	13,517	7,173	10,494	16,039	3,132	1,502	258	109	140	82	2	2,023,[illegible]
Non-psychotic organic brain syndrome associated with alcoholism (309.13)	1,394	170.6	24.6	68	146	114	186	149	101	225	98	122	52	26	30	58	.....	170,530
Drug dependence (304)	8,835	25.6	11.6	1,285	901	1,271	1,619	826	847	1,103	345	332	85	21	34	4	1	229,071
Non-psychotic organic brain syndrome associated with drug dependence (309.14)	108	40.5	15.7	5	11	13	22	16	12	9	9	4	2	1	.....	1	.....	4,254
Non-psychotic organic brain syndrome associated with other physical conditions (309.0, 309.2-309.9)	6,709	154.0	28.2	376	317	830	961	770	883	1,230	613	592	248	116	231	316	2	1,044,895
Mental retardation (310-315)	106	186.3	20.6	7	8	11	17	16	6	18	8	5	6	2	2	5	.....	17,634
All other non-psychotic mental disorders (Y00.1, Y03.4, 300-302, 305-307, 316, 318, 793.0)	20,467	30.4	14.1	3,231	2,989	3,094	5,111	3,205	3,079	4,449	1,467	1,210	276	103	121	50	3	696,041
VI. Diseases of nervous system and sense organs	43,997	30.2	8.8	3,007	6,499	10,767	8,631	4,114	2,853	3,211	1,160	1,128	326	165	208	218	4	1,329,949
Inflammatory diseases of central nervous system (320-324)	530	47.3	17.4	26	51	47	106	77	62	87	28	22	6	2	5	3	.....	25,040
Epilepsy (345)	2,940	19.1	9.3	279	409	583	749	246	196	197	46	46	9	7	6	7	.....	56,285
Amyotrophic lateral sclerosis (348.0)	423	43.4	14.2	23	50	53	66	56	27	64	16	19	7	3	6	3	.....	18,348
Paraplegia, cerebral or spinal (344.2, 349.3)	1,729	68.6	23.3	91	108	149	295	190	161	295	137	169	67	25	25	18	.....	118,046
Quadriplegia, cerebral or spinal (344.3, 349.4)	1,487	72.4	28.6	87	114	121	287	153	117	251	119	167	78	21	29	13	.....	107,[illegible]
Other diseases of central nervous system, including hereditary and familial disease of nervous system (330-333, 340-344.1, 344.9, 346-347, 349.1-349.2, 349.5-349.9)	8,[illegible]	74.6	17.2	496	717	990	1,664	1,201	893	1,216	540	474	133	77	106	164	1	658,[illegible]
Diseases of nerves and peripheral ganglia (350-358)	5,522	16.6	8.3	410	982	1,130	1,290	611	462	401	79	68	20	9	11	1	.....	91,230
Inflammatory diseases of the eye and other diseases and conditions of the eye, except blindness (360-369, 370-378)	17,643	10.5	6.0	1,790	2,626	6,417	4,470	1,170	588	407	79	72	7	7	15	8	3	185,380
Blindness (379)	789	28.8	21.7	46	62	83	131	78	59	145	90	83	6	3	1	.....	.....	31,434
Diseases of ear and mastoid process (380-389)	4,079	8.9	5.1	533	1,176	1,216	695	236	118	107	14	8	.....	1	5	1	.....	36,124
VII. Diseases of the circulatory system	141,822	24.0	11.6	8,815	16,851	26,010	37,306	26,462	12,781	11,919	3,125	2,080	681	235	457	325	4	3,400,887
Chronic rheumatic heart disease (393-398)	3,863	18.4	10.6	232	580	787	919	540	374	369	70	26	4	3	5	3	.....	63,231
Hypertensive heart disease, exclusive of ischemic heart disease (400.1, 402, 404)	3,698	16.6	10.2	133	497	893	1,032	449	254	240	64	26	9	2	5	1	.....	54,783
Hypertensive disease without heart involvement (400.0, 400.2, 400.3, 400.9, 401, 403)	10,135	15.1	8.4	1,063	1,689	2,181	2,570	1,099	710	578	106	90	24	4	16	5	.....	153,322
Acute myocardial infarction (410)	8,573	23.8	13.3	614	551	941	2,879	1,948	811	550	71	52	14	8	15	19	.....	203,695
Chronic ischemic heart disease (412)	39,760	19.4	10.6	2,018	5,550	8,423	11,205	5,702	3,249	2,466	457	397	93	34	100	82	1	770,433
Other ischemic heart disease, with or without hypertensive disease (411, 413, 414)	6,859	10.7	7.8	396	1,195	1,962	2,063	701	313	186	23	13	.....	1	4	2	.....	73,114

See footnotes at end of table.

TABLE 33—Continued

VA Medical Centers—Hospital Care Component: Patients Discharged, Diagnostic Grouping, Average and Median Length of Stay, Length of Stay Distribution[1]—Fiscal Year 1979—Continued

Principal Diagnoses[2]	Total Patients	Average Length of Stay	Median Length of Stay[3]	Length of Stay Distribution (Days) 1 Day	2-3	4-7	8-14	15-21	22-30	31-60	61-90	91-180	181-270	271-365	366-730	731 Plus	Un-known[5]	Total Days[6]
Other forms of heart disease (391, 392.0, 420-429)	21,902	19.1	9.8	1,727	2,790	4,934	5,885	2,798	1,677	1,455	295	196	41	14	47	42	1	417,569
Cerebral hemmorrhage (431)	868	34.9	15.0	117	81	83	153	110	74	130	50	51	11	2	3	3	.....	30,270
Cerebral thrombosis (433)	2,712	56.8	23.5	63	111	229	621	379	318	518	240	213	83	16	28	16	.....	154,015
Cerebral embolism (434)	115	29.5	19.8	1	6	12	23	23	18	17	7	8	.....	.....	.....	.....	.....	3,391
Generalized ischemic cerebrovascular disease (437)	1,173	61.2	17.1	37	89	143	263	181	141	178	46	34	16	10	20	15	1	71,764
All other cerebrovascular disease (430, 432, 435, 436, 438)	13,201	48.6	17.7	496	932	1,801	2,894	1,829	1,459	1,958	797	764	202	65	110	94	.....	641,559
Arteriosclerosis (440)	3,616	40.9	18.9	156	274	390	670	554	515	586	171	203	69	11	23	17	.....	148,071
All other diseases of arteries, arterioles and capillaries (441-448)	11,410	31.8	17.9	576	987	1,163	2,210	1,910	1,807	1,763	502	454	124	44	83	16	1	362,798
Varicose veins lower extremities (454)	2,347	23.6	13.3	184	229	298	850	293	245	302	88	98	6	4	9	1	.....	52,890
Hemorrhoids (455)	4,173	9.7	7.2	626	720	925	1,149	470	173	91	8	2	2	.....	6	1	.....	40,400
All other diseases of veins and lymphatics, and other diseases of circulatory system (390, 392.9, 450-453, 456-458)	7,701	20.7	13.0	477	860	1,046	2,382	1,458	783	840	131	91	23	8	13	9	.....	158,462
VIII. Diseases of the respiratory system	58,057	22.2	10.2	2,987	7,881	13,430	15,681	7,086	4,481	4,208	1,043	892	188	77	164	160	2	1,286,718
Acute respiratory infections including influenza (460-466, 470-474)	3,125	13.0	6.8	234	890	905	768	250	153	83	13	9	4	2	7	7	.....	40,771
Pneumonia (480-486)	11,643	37.2	12.3	500	923	2,348	3,408	1,708	1,038	1,040	269	180	52	33	58	86	.....	432,583
Bronchitis, unqualified and chronic (490-491)	6,119	20.5	10.0	318	776	1,451	1,787	738	437	404	91	64	18	8	12	15	.....	125,468
Emphysema (492)	13,869	21.1	11.4	615	1,405	2,913	4,118	1,883	1,181	1,075	315	216	63	14	42	28	1	292,786
Asthma (493)	3,039	10.8	7.3	196	532	986	819	289	131	101	16	5	3	1	5	1	1	32,832
All other diseases of upper respiratory tract and respiratory system (500-508, 510-519)	20,262	17.9	8.9	1,122	3,565	4,889	4,761	2,236	1,521	1,506	337	218	48	19	40	29	.....	362,279
IX. Diseases of the digestive system	86,514	16.9	10.4	6,691	10,446	17,665	23,819	11,148	6,927	6,380	1,348	782	122	56	95	64	1	1,445,182
Diseases of oral cavity, salivary glands, and jaws (520-529)	5,111	9.5	3.8	1,448	1,171	1,185	754	280	129	109	27	16	5	3	3	3	.....	48,519
Ulcers, digestive system (stomach, duodenum, peptic, gastrojejunal (531-534)	9,383	17.8	10.6	777	1,155	1,785	2,670	1,327	840	841	107	50	6	4	11	10	.....	167,077
All other diseases esophagus, stomach, and duodenum (except ulcers) (530, 535-537)	7,896	13.0	7.7	1,061	1,511	1,483	1,825	874	519	459	79	50	13	2	7	3	.....	102,722
Hernia of abdominal cavity (550-553)	19,675	12.7	9.8	786	1,852	5,569	7,300	2,383	1,049	723	106	58	10	5	14	9	.....	249,386
Other diseases of intestine and peritoneum (540-543, 560-569)	20,240	17.2	9.3	1,816	3,051	4,308	5,231	2,498	1,485	1,268	295	181	33	20	31	22	1	348,469
Alcoholic cirrhosis of liver (571.0)	9,511	25.3	16.8	316	706	1,190	2,146	1,575	1,279	1,641	381	210	33	13	17	5	.....	240,387
Other diseases of liver, gallbladder and pancreas (570, 571.8, 571.9, 572-577)	13,708	21.1	13.5	489	1,201	2,135	3,893	2,221	1,626	1,539	353	196	22	9	12	12	.....	288,623
X. Diseases of the genitourinary system	43,087	16.9	9.2	4,495	7,334	7,860	11,322	5,217	3,105	2,720	535	302	67	35	47	47	1	729,284
Nephritis and nephrosis (580-584)	6,096	19.7	9.5	619	910	815	995	550	431	508	148	79	18	9	9	5	.....	100,619
Other diseases of urinary system (590-599)	16,810	20.7	9.2	1,762	2,765	3,183	4,171	2,018	1,284	1,160	228	139	29	18	20	27	1	347,358
Diseases of the prostate (600-602)	12,951	16.3	10.9	1,340	1,896	1,933	4,395	2,104	1,145	891	135	65	17	8	10	12	.....	212,765
Other diseases of male genital organs (603-607)	5,772	10.1	8.4	520	1,414	1,561	1,427	452	188	144	21	18	6	.....	8	3	.....	68,283
Diseases of the breast, gynecological conditions (610-616, 620-629)	1,468	7.0	5.4	254	348	368	334	95	47	17	3	1	.....	.....	.....	.....	.....	10,239

XI. Deliveries and complications of pregnancy, childbirth and puerperium (630-678)	47	6.9	4.4	5	17	16	6	2	.....	.....	1	.....	.....	.....	.....	.....	.....	322
XII. Diseases of skin and subcutaneous tissue	20,899	16.7	8.6	4,783	3,422	3,513	3,646	1,776	1,300	1,485	437	341	89	44	39	14	.....	347,981
Infections of skin and subcutaneous tissue (680-682, 684-686)	9,742	17.0	9.1	828	1,480	2,196	2,314	1,083	752	772	168	104	22	7	9	7	.....	165,508
All other diseases of skin and subcutaneous tissue (690-698, 700-709)	11,157	16.4	3.4	3,955	1,942	1,317	1,332	693	548	723	269	237	67	37	30	7	.....	182,473
XIII. Diseases of the musculoskeletal system and connective tissue	37,844	19.0	11.6	3,085	4,818	6,487	8,810	5,395	3,972	3,775	731	540	112	45	74	18	2	719,035
Arthritis and rheumatism, except rheumatic fever (710-718)	13,846	21.8	13.7	877	1,381	1,989	3,343	2,215	1,722	1,652	326	243	50	24	38	6	.....	301,887
Displacement of intervertebral disc (725)	2,830	19.9	15.6	134	214	275	741	607	449	329	52	23	2	1	3	1	.....	56,234
Osteomyelitis and other diseases of bone and joint (720-724, 726-729)	13,634	18.8	11.3	1,204	1,701	2,469	3,114	1,874	1,356	1,387	272	171	37	16	23	8	2	256,056
Other diseases of musculoskeletal system (730-738)	7,534	13.9	7.2	870	1,522	1,754	1,612	699	445	408	81	103	23	4	10	3	.....	105,079
XIV. Congenital deformities (741-759)	2,982	15.2	9.1	431	475	488	646	356	245	250	56	34	5	3	3	.....	.....	46,377
XVI.A Symptoms and ill-defined conditions	51,132	15.3	7.7	5,487	9,537	11,389	12,805	5,384	2,959	2,446	525	344	83	30	77	65	1	780,457
Senility without mention of psychosis (794)	173	57.0	17.6	8	11	20	39	23	16	24	13	6	4	3	4	2	.....	9,853
Symptoms and all other ill-defined conditions (780-792, 795-796)	50,959	16.1	7.7	5,479	9,526	11,369	12,766	5,361	2,943	2,422	512	338	79	27	73	63	1	770,604
XVI.B Observation and examination cases, follow-up and special admissions	28,327	11.6	3.0	8,547	7,626	4,018	3,509	1,621	1,086	1,161	319	283	63	31	46	16	2	329,135
Tuberculosis (Y03.01, Y03.2, Y10.61-Y10.63)	311	31.1	11.2	26	49	54	59	32	27	20	12	14	4	1	4	.....	.....	9,675
Malignancy (793.1, Y03.3)	8,618	9.6	2.9	2,427	2,600	1,182	1,047	497	323	375	86	64	11	5	7	3	.....	82,624
All other admissions (793.8, 793.9, Y00.0, Y00.01, Y00.09, Y00.2-Y01, Y03.02, Y03.91-Y03.94, Y04-Y06, Y10.0-Y10.6, Y10.60, Y10.64-Y10.69, Y10.9, Y11-Y12, Y20-Y29)	19,108	12.3	3.0	5,943	4,910	2,743	2,391	1,087	730	761	220	203	48	25	33	13	1	235,120
Diagnosis deferred, mental observation (319.0, APA code)	290	5.9	(⁴)	151	67	39	12	5	6	5	1	2	.....	.....	1	.....	1	1,716
XVII. Accidents, poisonings, and nature of injury	53,011	22.3	8.4	7,848	8,524	9,650	10,278	5,290	3,764	4,471	1,424	1,227	261	120	179	81	4	1,180,260
Fracture of skull and facial bones (800-804)	2,157	14.3	7.5	244	371	538	559	185	99	105	22	22	4	1	4	3	.....	30,825
Fracture of skull and facial bones, late effects (800-804)⁷	370	30.5	8.4	20	58	94	84	37	20	17	12	10	4	2	1	3	.....	11,271
Fracture of spine and trunk (805-809)	2,715	25.2	11.9	164	361	481	640	329	238	298	97	62	16	17	11	4	.....	68,412
Fracture of spine and trunk, late effects (805-809)⁷	1,097	75.5	17.9	56	117	140	189	111	108	141	58	91	34	17	23	12	.....	82,836
Fracture of upper limb (810-819)	3,149	13.7	5.8	696	667	564	478	238	172	229	58	47	7	1	3	1	.....	43,000
Fracture of upper limb, late effects (810-819)⁷	741	13.0	7.8	70	128	182	178	80	63	40	5	15	.....	.....	.....	.....	.....	9,655
Fracture of lower limb (820-829)	8,325	38.5	17.0	715	716	869	1,533	1,204	995	1,279	461	390	66	28	46	32	1	320,283
Fracture of lower limb, late effects (820-829)⁷	1,748	29.1	14.3	123	168	261	382	234	173	243	83	70	17	3	11	2	.....	50,886
Dislocation without fracture (830-839)	1,504	14.1	7.4	244	201	366	390	124	80	66	15	2	2	2	2	2	.....	21,136
Dislocation without fracture, late effects (830-839)⁷	402	12.3	8.6	37	40	115	119	41	28	13	3	6	.....	.....	.....	.....	.....	4,939

See footnotes at end of table.

TABLE 33—Continued

VA Medical Centers—Hospital Care Component: Patients Discharged, Diagnostic Grouping, Average and Median Length of Stay, Length of Stay Distribution[1]—Fiscal Year 1979 —Continued

Principal Diagnoses[2]	Total Patients	Average Length of Stay	Median Length of Stay[3]	Length of Stay Distribution (Days) 1 Day	2-3	4-7	8-14	15-21	22-30	31-60	61-90	91-180	181-270	271-365	366-730	731 Plus	Unknown[5]	Total Days[8]
Intracranial injury — without skull fracture (850-854)	2,280	21.0	8.0	546	451	291	306	172	139	239	88	62	13	7	12	2	2	47,929
Intracranial injury — without skull fracture, late effects (850-854)[7]	822	45.1	13.2	85	114	96	157	83	66	86	38	50	18	9	17	2	.....	37,066
Internal injury of chest, abdomen and pelvis (860-869)	680	15.0	8.1	44	77	147	144	59	46	45	10	6	1	.....	2	.....	.....	9,249
Internal injury of chest, abdomen and pelvis, late effects (860-869)[7]	61	25.0	8.5	4	19	14	12	6	3	8	2	1	.....	.....	1	.....	.....	1,527
Traumatic amputation of arm and hand — complete/partial (887)	8	37.1	15.0	1	.....	2	1	1	1	1	.....	.....	1	.....	.....	.....	.....	297
Traumatic amputation of arm and hand — complete/partial late effects (887)[7]	12	11.0	12.7	2	1	1	3	5	.....	.....	.....	.....	.....	.....	.....	.....	.....	132
Traumatic amputation of foot and leg(s) — complete/partial (896-897)	32	56.1	29.6	2	1	2	2	4	6	6	3	6	1	.....	.....	.....	.....	1,796
Traumatic amputation of foot and leg(s) — complete/partial late-effects (896-897)[7]	39	37.0	14.0	4	3	6	7	3	4	5	3	2	.....	.....	1	.....	.....	1,405
Burns (940-949)	1,253	28.4	15.9	90	129	147	235	141	160	219	87	54	6	5	1	1	.....	35,590
Burns, late effects (940-949)[7]	187	28.5	17.3	5	12	18	38	32	17	32	4	8	2	.....	1	.....	.....	4,757
Injury to nerves and spinal cord (950-959)	225	29.1	10.0	33	59	55	56	40	23	25	14	11	4	2	.....	2	.....	8,446
Injury to nerves and spinal cord, late effects (950-959)[7]	485	54.1	13.3	35	65	65	103	54	32	55	15	40	9	6	2	4	.....	26,261
Adverse effect of medicinal agents and other complications of surgical and medical care (960-979, 997-999)	10,919	17.6	8.0	1,220	1,038	2,331	2,381	1,136	745	735	219	184	30	10	15	4	1	191,317
All other accidents, poisonings and violence (840-848, 870-879, 880-889, 890-895, 900-907, 910-918, 920-929, 930-939, 980-989)	12,887	12.1	4.8	3,264	2,672	2,550	2,128	862	526	561	158	106	21	7	28	7	.....	156,394
All other accidents, poisonings and violence, late effects (870-879, 880-889, 890-895, 900-907, 910-918, 920-929)[7]	934	14.9	7.2	117	169	225	184	99	51	56	11	14	4	5	.....	.....	.....	13,964
Unavailable[5]	6,790	40.0	13.0	515	730	1,153	1,403	802	582	826	297	256	88	46	47	46	.....	271,290

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[1] Patient treatment file. This table as well as all others in this hospital discharge series, excludes approximately 224,590 one-day dialysis discharges.

[2] The diagnostic categories and selected diagnoses included in this table are based on the "International Classification of Diseases adapted for Indexing of Hospital Records", USPHS Publication No. 1693. The numbers following the diagnosis are the identifying code numbers of this diagnostic classification. Category XV, "Certain Causes of Prenatal Morbidity and Mortality", in which no cases occurred, is not included in this table.

[3] One-half of the discharges in the given category have length of stay greater than the median; the other half, less than the median.

[4] No median computed since more than one-half of the cases had one day of stay.

[5] This column/line includes records for which required data is unavailable.

[6] In excess of 731 days and over.

[7] All late effect codes are differentiated from other codes by being uniformly .9 in the fourth digit.

[8] This column excludes those cases for which the number of days is unavailable.

TABLE 34 **INPATIENT CARE**

Surgical Procedures Performed in VA Medical Centers-Hospital Care Component[1]—Fiscal Year 1979

Operations and ICDA Codes	All Hospitals	Affiliated Hospitals	Non-Affiliated Hospitals
Surgical procedures (01-98)[2]	260,620	242,672	17,948
Neurosurgery (01-05)	7,635	7,352	283
Incision and excision of skull and intracranial structure (01)	1,549	1,545	4
Other operations on brain and cerebral meninges (02)	789	781	8
Operations on spinal cord structures (03)	1,213	1,203	10
Operations on peripheral nerves (04)	3,305	3,115	190
Operations on sympathetic nerves or ganglia (05)	679	608	71
Ophthalmology (06-14)	19,930	19,320	610
Operations on lacrimal apparatus (06)	170	169	1
Operations on eyelids (07)	3,516	3,379	137
Operations on conjunctiva (08)	756	720	36
Operations on orbit (09)	328	323	5
Operations on eyeball and muscles (10)	633	618	15
Operations on cornea and sclera (11)	676	671	5
Operations on iris and ciliary body (12)	1,050	1,027	23
Operations on choroid, anterior chamber and retina (13)	1,520	1,506	14
Operations on lens and vitreous (14)	11,282	10,907	375
Otorhinolaryngology (15-21)	16,100	15,585	515
Operations on external ear (15)	1,438	1,294	144
Operations on middle ear (17)	3,095	3,078	17
Operations on inner ear (18)	63	63	....
Operations on nose and accessory sinuses (19)	7,057	6,808	249
Operations on larynx and trachea (20)	3,541	3,469	72
Operations on pharynx, tonsils and adenoids (21)	906	873	33
Operations on thyroid, parathyroid, thymus, and adrenals (22-23)	966	913	53
Operations on thyroid and parathyroid (22)	901	850	51
Operations on thymus and adrenals (23)	65	63	2
Vascular and cardiac surgery (24-30)	33,669	32,707	962
Operations on peripheral blood vessels (24)	9,767	9,339	428
Operations on lymphatic system (25)	3,055	2,965	90
Operations on blood vessels of head, neck and base of brain (26)	2,671	2,618	53
Operations on intra-abdominal blood vessels (27)	4,001	3,808	193
Operations on intrathoracic vessels (28)	306	302	4
Operations on heart and pericardium (29)	4,691	4,690	1
Other heart procedures (30)	9,078	8,985	93
Thoracic surgery (32-35)	6,974	6,498	476
Operations on chest wall, pleura, and mediastinum (32)	2,644	2,469	175
Operations on bronchus (33)	69	66	3
Operations on lung (34)	2,642	2,471	171
Operations on esophagus (35)	1,619	1,492	127
Abdominal surgery (38-48)	51,380	46,593	4,787
Repair of Hernia (38)	18,306	16,148	2,158
Incision and excision of abdominal wall region (39)	6,523	6,038	485
Other operations on region of abdomen and peritoneum (40)	1,863	1,724	139
Operations on appendix (41)	2,419	2,165	254
Operations on liver (42)	164	158	6
Operations on biliary tract (43)	6,123	5,627	496
Operations on pancreas (44)	515	496	19
Operations on spleen (45)	720	691	29
Operations on stomach (46)	6,105	5,647	458
Incision, excision, resection and enterostomy of intestines (47)	6,164	5,688	476
Anastomosis, repair and other operations on the intestines (48)	2,488	2,311	177
Proctological surgery (50-52)	7,792	6,614	1,178
Operations on rectum (50)	2,137	1,922	215
Operations on anus (51)	5,000	4,113	887
Operations on pilonidal sinus or cyst (52)	655	579	76

See footnotes at end of table.

Surgical Procedures Performed in VA Medical Centers—Hospital Care Component[1]*—Fiscal Year 1979—Continued*

Operations and ICDA Codes	All Hospitals	Affiliated Hospitals	Non-Affiliated Hospitals
Urological surgery (54-61)	37,106	34,057	3,049
Operations on kidney (54)	2,208	2,107	101
Operations on ureter (55)	1,888	1,785	103
Operations on urinary bladder (56)	6,326	5,767	559
Operations on urethra (57)	4,157	3,882	275
Operations on prostate and seminal vesicles (58)	13,352	12,188	1,164
Operations on scrotum and contents and spermatic cord (59)	4,132	3,739	393
Operations on epididymis and vas deferens (60)	1,587	1,364	223
Operations on penis (61)	3,455	3,224	231
Breast surgery (65)	833	759	74
Gynecological surgery (67-72)	647	578	69
Operations on ovary (67)	135	125	10
Operations on fallopian tubes (68)	25	25	....
Hysterectomy (69)	135	125	10
Other operations on uterus and supporting structures (70)	251	217	34
Operations on vagina (71)	81	67	14
Operations on vulva and perineum (72)	20	19	1
Obstetrical procedures (74-78)	14	14	....
Antepartum obstetrical operations (74)	2	2	....
Operations inducing or assisting delivery (75)	....	....	....
Operations inducing or assisting delivery (cont'd) (76)	....	....	....
Cesarean section (77)	....	....	....
Operations after delivery or abortion (78)	12	12	....
Orthopedic surgery (80-90)	40,050	37,450	2,600
Incision and excision of bones (80)	6,316	5,900	416
Repair and plastic operations on bone (81)	2,580	2,412	168
Reduction of fracture and fracture-dislocation of hip (82)	2,434	2,270	164
Reduction of fracture and fracture-dislocation of ankle and wrist (83)	1,307	1,198	109
Reduction of other fracture and fracture-dislocation (84)	2,187	2,048	139
Amputation and disarticulation of extremities (85)	6,138	5,650	488
Incision and excision of joint structures (86)	6,147	5,798	349
Other operations on joint structures (87)	7,601	7,255	346
Operations on muscles, tendons, fascia and bursa except of hand (88)	3,298	3,026	272
Operations on muscles, tendon and fascia of hand (89)	2,037	1,888	149
Reattachment of extremities (90)	5	4	1
Plastic surgery (92-94)	32,721	29,374	3,347
Operations on skin and subcutaneous tissue (92)	24,572	21,615	2,957
Reparative and reconstructive surgery (93)	7,260	6,883	377
Reparative and reconstructive surgery (cont'd) (94)	889	876	13
Oral and maxillofacial surgery (95-98)	4,903	4,759	144
Operations on salivary glands and ducts (95)	753	711	42
Operations on buccal cavity, tongue and palate (96)	1,371	1,334	37
Operations on jaws (bone and joint) (97)	1,579	1,548	31
Reduction of fracture and fracture-dislocation of jawbone (98)	1,200	1,166	34

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[1] *Patient treatment file. The procedures included in this table are grouped on the "International Classification of Diseases Adapted for Indexing of Hospital Records", USPHS Publication No. 1693. The numbers following the operations are the identifying code numbers of this operation classification.*

[2] *For purposes of this table, dental, diagnostic and therapeutic procedures are excluded.*

TABLE 35

INPATIENT CARE

Cost of Operation of Medical Inpatient Facilities— Fiscal Year 1979

(Dollars in Thousands)

Activity	Total	VA Hospital Care: Medical Bed Section	VA Hospital Care: Surgical Bed Section	VA Hospital Care: Psychiatric Bed Section	VA Nursing Care	VA Domiciliaries
Total Costs	$3,917,648	$1,873,746	$984,820	$790,478	$188,503	$80,101
Professional and auxiliary:						
Medical Services[1]	944,075	473,139	267,146	168,794	23,103	11,892
Nursing Services	944,133	454,997	236,770	194,233	55,614	2,519
Chaplain Services	17,841	7,584	3,280	4,456	1,332	1,189
Dietetics Services	310,541	130,452	54,932	76,396	26,518	22,242
Dental Services	39,062	16,988	8,312	10,451	1,532	1,769
Audiology & Speech Pathology	4,733	3,037	870	310	348	156
Direct Care, Total	2,260,374	1,086,199	571,310	454,650	108,448	39,768
Administrative Support	459,353	220,800	111,845	95,982	20,759	9,966
Engineering Support	457,369	196,663	93,967	113,380	32,818	20,540
Building Management[2]	230,824	104,037	50,512	56,072	15,314	4,888
Research Support	73,904	44,415	19,759	8,756	635	339
Education & Training Support	242,169	124,766	80,313	33,516	2,537	1,036
Asset Acquisitions	193,665	96,866	57,114	28,123	7,991	3,563
Support, Total	1,657,274	787,547	413,511	335,828	80,054	40,333

[1] *Professional medical services include laboratory, pharmacy, blind rehabilitation, clinical nuclear medicine, rehabilitation medicine, social service, clinical psychology, radiology, medical illustration and library.*

[2] *Includes operation of laundry.*

TABLE 36

EXTENDED CARE

VA Nursing Homes, Community Nursing Homes, and VA Domiciliaries: Patient Movement Fiscal Year 1979

Item	VA Nursing Homes	Community Nursing Homes	VA Domiciliaries
Total on rolls (bed occupants and in absent status) remaining on September 30, 1978	7,878	8,353	9,565
Gains during Fiscal Year 1979 – Total	8,209	23,629	12,508
Direct gains – Total	4,428	19,825	6,920
Admissions after rehospitalization	391	1,583[2]	961[2]
Other Admissions	4,037	18,242	5,959
Transfers in from similar facilities[3]	85	624	83
Returns from absent sick in hospital status	3,696	3,080	5,505
Losses during Fiscal Year 1979 – Total	7,995	23,146	13,012
Discharges and deaths while in bed occupant or authorized leave of absence status – Total	2,716	14,478	4,962
Discharges	2,027	11,485	4,825
Deaths	689	2,993	137
Discharges and deaths while in absent sick in hospital status-Total	1,474	4,493	2,518
Discharges	894	3,441	2,366
Deaths	580	1,052	152
Transfers out to similar facilities[3]	90	562	61
Losses to absent sick in hospital status	5,179	8,106	7,999
Remaining on September 30, 1979 – Total	8,092	8,836	9,061
Bed occupants	7,846	8,572	8,271
On authorized leave of absence	71	17	507
Absent sick in hospital	175	247	283
Patients treated during Fiscal Year 1979[4]	12,282	27,807	16,541
Average daily census during Fiscal Year 1979[5]	7,760	8,126	8,448

[1] *Admissions after rehospitalization of more than 30 days.*

[2] *Admissions after rehospitalization of more than 15 days.*

[3] *Includes only patients transferred as VA beneficiaries.*

[4] *Discharges and deaths during Fiscal Year 1979 plus the number remaining on the rolls on September 30, 1979.*

[5] *Based on the number of patients days during the fiscal year divided by the number of days in the fiscal year.*

State Home Hospitals, State Nursing Homes, and State Domiciliary Homes: Patient Movement[1]—Fiscal Year 1979

	State Home Hospitals	State Nursing Homes	State Domiciliary Homes
Bed occupants remaining on September 30, 1978	986	5,036	4,935
Gains during Fiscal Year 1979 – Total	5,683	8,283	13,183
Direct gains – Total	5,200	4,187	5,288
Admissions from State Facilities	2,463	1,933	1,771
Other admissions	2,737	2,254	3,517
Returns from leave of absence status	483	4,096	7,895
Losses during Fiscal Year 1979 – Total	5,692	8,099	13,255
Discharges and deaths – Total	5,208	3,934	5,351
Discharges to State Facilities	2,304	1,780	2,099
Other discharges	2,419	1,231	3,064
Deaths	482	923	188
Losses to leave of absence status	484	4,165	7,904
Bed occupants remaining on September 30, 1979	984	5,348	5,184
Patients treated during Fiscal Year 1979[2]	6,192	9,282	10,535
Average daily census during Fiscal Year 1979[3]	980	5,203	5,296

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[1] Data include only patients supported by VA.

[2] Based on discharges and deaths during Fiscal Year 1979, plus the number on the rolls on September 30, 1979.

[3] Based on the number of patient days during the fiscal year divided by the number of days in the fiscal year.

VA Medical Centers—Domiciliary Care Component: Selected Data Fiscal Year 1979

Location	Average Operating Beds 1	Bed Occupancy Rate (%) 2	Average Daily Census 3	Admissions 4	Discharges 4 5	Patients Treated 4 6	Remaining on Sept. 30, 1979 7
Total	9,655	87.5	8,448	6,620	7,480	16,541	9,061
Arizona:							
Prescott	237	92.9	221	185	170	440	270
California: Los Angeles	450	78.0	351	213	263	634	371
Florida: Bay Pines	322	88.5	285	156	177	492	315
Georgia: Dublin	381	98.4	375	217	254	627	373
Kansas: Leavenworth	775	91.0	705	1,076	1,074	1,974	900
Mississippi: Biloxi	470	87.7	412	343	366	820	454
New York: Bath	665	91.2	606	447	468	1,121	653
Ohio: Dayton	905	83.9	759	613	707	1,478	771
Oregon: White City	1,165	89.4	1,043	902	994	2,123	1,129
South Dakota: Hot Springs	500	83.1	417	451	525	961	436
Tennessee: Mountain Home	832	91.8	765	644	673	1,444	771
Texas:							
Bonham	230	93.2	214	196	208	456	248
Temple	550	85.4	470	601	639	1,130	491
Virginia: Hampton	780	80.7	629	350	357	1,036	679
West Virginia: Martinsburg	568	91.8	521	238	271	813	542
Wisconsin: Wood	752	94.9	714	343	404	1,124	720

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[1] Based on the number of operating beds at the end of each month of 13 consecutive months (September 1978 – September 1979).

[2] Average daily census as a percent of the average operating beds.

[3] Based on the number of patient days during the fiscal year divided by the number of days in the fiscal year.

[4] Transfers included in individual facility totals; excluded from overall total.

[5] Includes deaths.

[6] Discharges and deaths during the fiscal year plus the number of patients on the rolls at the end of the fiscal year.

[7] Total on rolls (bed occupants, patients on authorized leave of absence, and patients absent sick in hospital).

VA Medical Centers—Nursing Home Care Component: Selected Data—Fiscal Year 1979

Location	Average Operating Beds 1	Bed Occupancy Rate (%) 2	Average Daily Census 3	Admissions 4	Discharges 4 5	Patients Treated 4 6	Remaining on Sept. 30, 1979 7
Total	8,257	94.2	7,780	4,420	4,190	12,283	8,093
Alabama:							
Tuscaloosa	120	93.3	112	32	37	154	117
Tuskegee	112	96.2	108	31	30	142	112
Arizona:							
Phoenix	120	80.0	96	107	59	170	111
Tucson	41	95.1	39	27	25	66	41
Arkansas: Little Rock	200	91.5	183	90	54	252	198
California:							
Loma Linda	50	93.3	46	283	167	226	59
Long Beach	180	91.7	165	195	183	353	170
Palo Alto	180	90.7	163	49	21	148	127
San Diego	60	91.7	55	96	98	155	57
Sepulveda	200	72.0	144	113	66	223	157
Colorado:							
Ft. Lyon	37	91.9	34	16	15	50	35
Grand Junction	42	97.6	41	10	11	52	41
Connecticut: West Haven	90	100.0	90	17	12	106	94
Delaware: Wilmington	60	95.0	57	73	23	83	60
Florida:							
Bay Pines	120	96.7	116	78	76	195	119
Lake City	40	97.5	39	18	18	57	39
Miami	90	96.7	87	180	116	200	84
Georgia:							
Augusta	40	95.0	38	12	15	52	37
Dublin	85	96.5	82	27	26	113	87
Illinois:							
Danville	120	95.0	114	57	59	174	115
North Chicago	190	95.3	181	43	43	232	189
Indiana:							
Ft. Wayne	54	92.6	50	31	16	70	54
Indianapolis	60	96.7	58	21	20	80	60
Marion	92	91.3	84	38	33	101	68
Iowa: Knoxville	200	95.0	190	106	83	281	198
Kansas:							
Leavenworth	45	93.3	42	22	22	65	43
Topeka	79	93.7	74	16	18	90	72
Kentucky: Lexington	100	91.0	91	32	32	122	90
Louisiana: Alexandria	93	78.5	73	19	24	112	88
Maine: Togus	60	96.7	58	20	10	70	60
Maryland:							
Ft. Howard	47	100.0	47	6	6	53	47
Perry Point	80	95.0	76	30	36	113	77
Massachusetts:							
Bedford	162	95.7	155	24	29	185	156
Brockton	100	97.0	97	32	31	131	100
Northampton	50	98.0	49	9	9	59	50
Michigan:							
Allen Park	72	98.6	71	28	26	98	72
Battle Creek	205	93.2	191	34	35	230	195
Iron Mountain	40	92.5	37	12	12	52	40
Minnesota: St. Cloud	44	93.2	41	17	14	58	44
Mississippi:							
Biloxi	35	97.1	34	8	7	42	35
Jackson	120	95.0	114	28	30	147	117
Missouri:							
Columbia	54	96.4	52	14	12	66	54
Poplar Bluff	50	100.0	50	106	96	146	50
St. Louis	93	96.8	90	17	17	109	92
Montana: Miles City	26	100.0	26	15	14	40	26
Nebraska: Grand Island	42	85.7	36	23	27	64	37
Nevada: Reno	22	100.0	21	8	8	30	22
New Hampshire: Manchester	120	98.3	118	210	221	341	120
New Jersey:							
East Orange	60	95.0	57	63	62	121	59
Lyons	90	96.7	87	37	32	124	92
New Mexico: Albuquerque	47	93.6	44	61	58	102	44

See footnotes at end of table.

VA Medical Centers—Nursing Home Care Component: Selected Data—Fiscal Year 1979—Continued

Location	Average Operating Beds 1	Bed Occupancy Rate (%) 2	Average Daily Census 3	Admissions 4	Discharges 4 5	Patients Treated 4 6	Remaining on Sept. 30, 1979 7
New York:							
Albany	66	101.5	73	22	46	111	65
Bath	198	85.7	170	123	154	322	168
Brooklyn	300	96.3	290	129	129	422	293
Buffalo	36	97.2	35	25	26	61	35
Canandaigua	100	100.0	99	25	24	124	100
Castle Point	148	97.3	144	28	29	176	147
Montrose	122	94.3	115	32	35	151	116
Syracuse	40	96.0	38	18	25	63	38
North Carolina:							
Asheville	82	96.1	79	19	21	102	81
Fayetteville	39	97.4	38	24	25	63	38
Salisbury	93	97.8	91	66	69	162	93
North Dakota: Fargo	50	94.0	47	64	64	114	50
Ohio:							
Chillicothe	95	97.0	92	63	51	149	98
Cincinnati	206	93.2	193	155	158	348	190
Cleveland	100	98.0	97	50	50	150	100
Dayton	300	96.0	288	99	109	401	292
Oregon: Roseburg	75	94.7	72	44	45	119	74
Pennsylvania:							
Altoona	33	75.8	25	61	42	68	26
Butler	104	93.3	97	34	35	137	102
Coatesville	50	96.0	48	19	19	69	50
Erie	40	95.0	38	19	16	54	38
Lebanon	120	99.2	119	14	15	134	119
Pittsburgh (Gen.)	228	93.9	213	102	124	350	226
South Carolina: Columbia	72	96.8	70	65	58	128	70
South Dakota: Sioux Falls	75	93.3	72	30	30	103	73
Tennessee:							
Mountain Home	58	96.6	56	16	18	74	56
Murfreesboro	48	100.0	47	11	11	59	48
Texas:							
Big Spring	40	100.0	38	105	90	130	40
Bonham	100	95.0	95	28	26	125	99
Houston	78	97.4	76	53	52	130	78
Kerrville	35	94.3	33	7	7	42	35
Waco	84	100.0	84	41	43	127	84
Utah: Salt Lake City	46	73.9	34	100	108	143	35
Vermont: White River Junction	30	93.3	28	96	99	128	29
Virginia:							
Hampton	40	92.5	37	16	19	56	37
Salem	100	94.0	94	63	73	167	94
Washington: American Lake	75	97.4	73	18	14	89	75
West Virginia: Beckley	42	95.7	40	13	19	55	36
Wisconsin:							
Tomah	100	96.0	96	22	33	131	98
Wood	200	97.5	195	46	47	246	199
Wyoming: Cheyenne	47	97.9	46	20	19	66	47

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[1] *Based on the number of operating beds at the end of September 1979.*

[2] *Average daily census as a percent of the average operating beds.*

[3] *Based on the number of patient days during the fiscal year divided by the number of days in the fiscal year.*

[4] *Transfers included in individual facility totals excluded from overall total.*

[5] *Includes deaths.*

[6] *Discharges and deaths during the fiscal year plus the number of patients on the rolls at the end of the fiscal year.*

[7] *Total on rolls (bed occupants, patients on authorized leave of absence, and patients sick in hospital).*

State Nursing Care Homes: Selected Data—Fiscal Year 1979

Location of State Home Hospital	Location of Authorizing VA Facility	Average Daily Census [1]	Admissions	Discharges [2]	Patients Treated [3]	Remaining on September 30, 1979 [4]
Total		5,253	4,187	3,834	9,182	5,348
California: Yountville	San Francisco, CA	323	450	468	785	317
Colorado: Florence	Denver, CO	107	61	71	176	105
Homelake	Denver, CO	17	13	16	30	14
Georgia:						
Augusta	Augusta, GA	176	188	163	342	179
Milledgeville	Dublin, GA	124	36	29	156	127
Illinois: Quincy	Iowa City, IA	310	510	487	787	300
Indiana: Lafayette	Indianapolis, IN	150	47	77	227	150
Iowa: Marshalltown	Des Moines, IA	254	182	151	406	255
Kansas: Fort Dodge	Wichita, KS	50	16	26	79	53
Massachusetts:						
Chelsea	Boston, MA (OPC)	55	212	213	269	56
Holyoke	Northampton, MA	231	171	167	402	235
Michigan: Grand Rapids	Allen Park, MI	488	209	184	690	506
Minnesota: Minneapolis	Minneapolis, MN	53	47	56	139	83
Missouri: St. James	St. Louis, MO	97	104	90	190	100
Montana: Columbia Falls	Ft. Harrison, MT	38	32	32	72	40
Nebraska: Grand Island	Grand Island, NE	369	162	159	526	367
New Hampshire: Tilton	Manchester, NH	88	40	32	121	89
New Jersey:						
Menlo Park	East Orange, NJ	280	56	56	319	263
Vineland	Wilmington, DE	237	114	90	335	245
New York: Oxford	Syracuse, NY	26	35	32	71	39
Ohio: Sandusky	Cleveland, OH	22	105	5	68	63
Oklahoma:						
Ardmore	Oklahoma City, OK	77	76	79	155	76
Clinton	Oklahoma City, OK	161	164	165	317	152
Norman	Oklahoma City, OK	47	19	20	65	45
Sulphur	Oklahoma City, OK	130	131	134	265	131
Talihina	Oklahoma City, OK	150	152	150	300	150
Pennsylvania:						
Hollidaysburg	Altoona, PA	33	66	33	66	33
Erie	Erie, PA	66	15	19	87	68
Rhode Island: Bristol	Providence, RI	223	95	61	290	229
South Carolina: Columbia	Columbia, SC	102	95	76	186	110
South Dakota: Hot Springs	Hot Springs, SD	27	8	11	41	30
Vermont: Bennington	White River Junction, VT	119	137	117	244	127
Washington:						
Orting	Seattle, WA	73	47	45	124	79
Retsil	Seattle, WA	73	107	115	186	71
Wisconsin: King	Madison, WI	411	321	297	730	433

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[1] *Based on the number of patient days during the fiscal year divided by the number of days in the fiscal year.*

[2] *Includes deaths.*

[3] *Discharges and deaths during the fiscal year plus the number of patients on the rolls at the end of the fiscal year.*

[4] *Total on rolls (bed occupants, patients on leave of absence, and patients absent sick in hospital).*

Community Nursing Homes: Selected Data—Fiscal Year 1979

Location of Authorizing VA Facility	Average Daily Census 1	Admissions 2	Discharges 2 3	Patients Treated 2 4	Remaining on September 30, 1979 5
Total	8,126	19,925	18,971	27,807	8,836
Alabama:					
Birmingham	58	172	160	226	66
Montgomery	17	37	32	49	17
Tuscaloosa	52	99	101	155	54
Tuskegee	17	30	26	40	14
Alaska: Anchorage	10	31	28	39	11
Arizona:					
Phoenix	147	351	281	438	157
Prescott	6	12	10	17	7
Tucson	62	179	160	231	71
Arkansas:					
Fayetteville	13	51	44	57	13
Little Rock	106	251	182	292	110
California:					
Fresno	35	106	91	121	30
Livermore	24	51	52	75	23
Loma Linda	33	136	85	139	54
Long Beach	140	518	501	653	152
Los Angeles (Brentwood)	68	97	84	156	72
Los Angeles (Wadsworth)	104	326	320	432	112
Martinez	31	87	66	111	45
Palo Alto	65	159	160	231	71
San Diego	41	61	84	112	28
San Francisco	39	148	142	180	38
Sepulveda	69	101	82	176	94
Colorado:					
Denver	54	127	128	180	52
Ft. Lyon	38	14	15	46	31
Grand Junction	22	69	63	88	25
Connecticut:					
Newington	37	128	113	152	39
West Haven	30	78	88	114	26
Delaware: Wilmington	78	199	145	242	97
District of Columbia: Washington	70	149	165	223	58
Florida:					
Bay Pines	146	357	342	502	160
Gainesville	73	186	175	245	70
Lake City	15	48	45	62	17
Miami	106	249	270	396	126
Tampa	136	468	425	585	160
Georgia:					
Atlanta	87	275	279	368	89
Augusta	103	182	199	296	97
Dublin	34	99	101	140	39
Hawaii: Honolulu	10	30	25	37	12
Idaho: Boise	31	135	133	172	39
Illinois:					
Chicago (Lakeside)	82	245	229	318	89
Chicago (West Side)	89	233	182	274	92
Danville	37	155	136	184	48
Hines	148	506	470	643	173
Marion	51	145	127	183	56
North Chicago	96	126	93	226	133
Indiana:					
Ft. Wayne	23	85	94	109	15
Indianapolis	45	142	147	194	47
Marion	62	66	52	123	71
Iowa:					
Des Moines	53	158	143	202	59
Iowa City	64	225	232	302	70
Knoxville	86	74	105	155	50
Kansas:					
Leavenworth	38	104	104	148	44
Topeka	49	94	87	144	57
Wichita	11	43	44	56	12
Kentucky:					
Lexington	70	185	202	269	67
Louisville	47	159	111	165	54

See footnotes at end of table.

Community Nursing Homes: Selected Data—Fiscal Year 1979—Continued

Location of Authorizing VA Facility	Average Daily Census [1]	Admissions [2]	Discharges [2 3]	Patients Treated [2 4]	Remaining on September 30, 1979 [5]
Louisiana:					
Alexandria	16	60	62	77	15
New Orleans	53	142	162	215	53
Shreveport	47	174	164	201	37
Maine: Togus	43	99	87	130	43
Maryland:					
Baltimore	29	98	70	112	42
Ft. Howard	28	37	48	68	20
Perry Point	28	23	28	50	22
Massachusetts:					
Bedford	68	74	68	141	73
Boston	66	192	187	258	71
Brockton	39	57	52	100	48
Northampton	40	44	37	87	50
West Roxbury	7	20	20	27	7
Michigan:					
Allen Park	78	167	164	232	68
Ann Arbor	40	138	141	181	40
Battle Creek	45	96	47	104	57
Iron Mountain	8	25	23	33	10
Saginaw	30	119	83	133	50
Minnesota:					
Minneapolis	130	381	329	503	174
St. Cloud	49	63	66	117	51
Mississippi:					
Biloxi	74	141	105	195	90
Jackson	28	90	81	116	35
Missouri:					
Columbia	34	111	114	159	45
Kansas City	68	183	207	279	72
Poplar Bluff	30	97	94	116	22
St. Louis	83	216	224	316	92
Montana:					
Ft. Harrison	31	68	65	102	37
Miles City	15	55	50	69	19
Nebraska:					
Grand Island	4	8	7	11	4
Lincoln	18	45	48	67	19
Omaha	36	194	179	228	49
Nevada: Reno	17	52	55	65	10
New Hampshire: Manchester	40	96	90	134	44
New Jersey:					
East Orange	132	216	226	345	119
Lyons	35	39	37	72	35
New Mexico: Albuquerque	46	167	153	204	51
New York:					
Albany	27	48	43	74	31
Batavia	4	9	10	13	3
Bath	8	19	14	23	9
Bronx	20	41	34	58	24
Brooklyn	23	57	33	61	28
Buffalo	31	58	51	84	33
Canandaigua	2	4	1	4	3
Castle Point	5	11	9	14	5
Montrose	9	5	7	15	8
New York	8	25	12	28	16
Northport	21	14	5	30	25
Syracuse	16	28	27	39	12
North Carolina:					
Asheville	48	95	76	131	55
Durham	49	138	130	178	48
Fayetteville	41	103	110	150	40
Salisbury	44	55	46	98	52
North Dakota: Fargo	24	57	57	80	23
Ohio:					
Chillicothe	149	217	223	394	171
Cincinnati	42	190	189	237	48
Cleveland	134	309	276	423	147
Dayton	61	117	116	177	61

See footnotes at end of table.

Community Nursing Homes: Selected Data–Fiscal Year 1979–Continued

Location of Authorizing VA Facility	Average Daily Census [1]	Admissions [2]	Discharges [2 3]	Patients Treated [3 4]	Remaining on September 30, 1979 [5]
Oklahoma:					
Muskogee	41	177	163	212	49
Oklahoma City	55	256	307	387	80
Oregon:					
Portland	90	271	254	349	95
Roseburg	69	178	187	250	63
Pennsylvania:					
Altoona	21	52	44	67	23
Butler	17	26	27	42	15
Coatesville	131	103	92	235	143
Erie	18	38	40	59	19
Lebanon	35	41	35	71	36
Philadelphia	69	144	122	205	83
Pittsburgh (University Dr)	77	211	195	287	92
Pittsburgh (Highland Dr)	52	45	36	91	55
Wilkes-Barre	46	95	92	140	48
Puerto Rico: San Juan	43	150	145	195	50
Rhode Island: Providence	38	110	117	149	32
South Carolina:					
Charleston	39	99	118	143	25
Columbia	75	161	176	251	75
South Dakota:					
Ft. Meade	5	11	9	15	6
Hot Springs	6	16	18	22	4
Sioux Falls	22	92	87	112	25
Tennessee:					
Memphis	32	84	73	112	39
Mountain Home	110	153	184	286	102
Murfreesboro	8	24	13	31	18
Nashville	65	142	131	188	57
Texas:					
Amarillo	23	82	85	104	19
Big Spring	41	111	88	136	48
Bonham	25	84	85	117	32
Dallas	100	383	375	481	106
Houston	113	469	461	585	124
Kerrville	36	117	121	163	42
Marlin	16	44	46	63	17
San Antonio	91	302	306	401	95
Temple	70	216	194	290	96
Waco	75	104	107	182	75
Utah: Salt Lake City	35	113	97	144	47
Vermont: White River Junction	13	39	31	48	17
Virginia:					
Hampton	32	78	78	122	44
Richmond	50	136	129	183	54
Salem	81	108	94	167	73
Washington:					
American Lake	26	33	31	56	25
Seattle	190	276	271	375	104
Spokane	42	147	129	186	57
Vancouver	59	166	158	220	62
Walla Walla	17	54	45	66	21
West Virginia:					
Beckley	14	52	40	50	10
Clarksburg	54	158	132	210	78
Huntington	63	186	197	283	86
Martinsburg	70	165	180	240	60
Wisconsin:					
Madison	23	64	40	67	27
Tomah	31	65	35	84	49
Wood	95	240	255	352	97
Wyoming:					
Cheyenne	11	49	40	58	18
Sheridan	24	39	38	59	21

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[1] *Based on the number of patient days during the fiscal year divided by the number of days in the fiscal year.*

[2] *Transfers included in individual facility totals; excluded from overall total.*

[3] *Includes deaths.*

[4] *Discharges and deaths during the fiscal year plus the number of patients on the rolls at the end of the fiscal year.*

[5] *Total on rolls (bed occupants, patients on authorized leave of absence, and patients absent sick in hospital).*

TABLE 42

EXTENDED CARE

State Domiciliary Homes: Selected Data—Fiscal Year 1979

Location of State Home Domiciliary	Location of Authorizing VA Facility	Average Daily Census 1	Admissions	Discharges 2	Patients Treated 3	Remaining on September 30, 1979 4
Total		5,290	5,308	5,352	10,536	5,184
California: Yountville	San Francisco, CA	650	964	931	1,577	646
Colorado: Homelake	Denver, CO	72	32	29	106	77
Connecticut: Rocky Hill	Newington, CT	431	574	531	942	411
Georgia: Milledgeville	Dublin, GA	272	256	58	333	275
Idaho: Boise	Boise, ID	110	107	111	216	105
Illinois: Quincy	Iowa City, IA	90	150	120	215	95
Indiana: Lafayette	Indianapolis, IN	88	41	41	118	77
Iowa: Marshalltown	Des Moines, IA	89	77	71	160	89
Kansas: Fort Dodge	Wichita, KS	62	19	19	78	59
Louisiana: Jackson	New Orleans, LA	109	101	56	171	115
Massachusetts:						
Chelsea	Boston, MA (OPC)	260	336	326	578	252
Holyoke	Northampton, MA	39	39	41	81	40
Michigan: Grand Rapids	Allen Park, MI	165	87	101	259	158
Minnesota:						
Hastings	Minneapolis, MN	64	339	89	221	132
Minneapolis	Minneapolis, MN	415	387	492	839	347
Missouri: St. James	St. Louis, MO	63	72	77	135	58
Montana: Columbia Falls	Ft. Harrison, MT	75	44	48	124	76
Nebraska: Grand Island	Grand Island, NE	141	70	74	219	145
New Jersey:						
Menlo Park	East Orange, NJ	94	38	31	128	97
Vineland	Wilmington, DE	37	31	29	64	35
New York: Oxford	Syracuse, NY	33	39	18	56	38
North Dakota: Lisbon	Fargo, ND	109	27	31	137	106
Ohio: Sandusky	Cleveland, OH	662	390	340	980	640
Oklahoma:						
Ardmore	Oklahoma City, OK	89	232	231	316	85
Clinton	Oklahoma City, OK	35	105	108	141	33
Norman	Oklahoma City, OK	101	27	135	237	102
Sulphur	Oklahoma City, OK	31	67	63	89	26
Pennsylvania:						
Hollidaysburg	Altoona, PA	35	50	39	91	52
Erie	Erie, PA	64	29	27	90	63
Rhode Island: Bristol	Providence, RI	102	38	52	147	95
South Dakota: Hot Springs	Hot Springs, SD	90	33	29	126	97
Vermont: Bennington	White River Jct., VT	12	16	17	29	12
Virginia: Occoquan[5]	Washington, DC	171	547	553	719	166
Washington:						
Orting	Seattle, WA	72	94	60	131	71
Retsil	Seattle, WA	139	130	127	270	143
Wisconsin: King	Madison, WI	40	40	60	94	34
Wyoming: Buffalo	Sheridan, WY	46	12	9	55	46

[1] Based on the number of patient days during the fiscal year divided by the number of days in the fiscal year.

[2] Includes deaths.

[3] Discharges and deaths during the fiscal year plus the number of patients on the rolls at the end of the fiscal year.

[4] Total on rolls (bed occupants, patients on leave of absence, and patients absent sick in hospital).

[5] Operated by the government of the District of Columbia.

TABLE 43

EXTENDED CARE

State Home Hospitals: Selected Data—Fiscal Year 1979

Location of State Home Hospitals	Location of Authorizing VA Facility	Average Daily Census 1	Admissions	Discharges 2	Patients Treated 3	Remaining on September 30, 1979 4
Total		980	5,300	5,296	6,182	886
California: Yountville	San Francisco, CA	370	1,097	1,084	1,456	372
Connecticut: Rocky Hill	Newington, CT	324	857	582	809	227
Illinois: Quincy	Iowa City, IA	24	418	405	437	32
Iowa: Marshalltown	Des Moines, IA	114	142	172	281	109
Massachusetts:						
Chelsea	Boston, MA (OPC)	114	1,921	1,926	2,038	112
Holyoke	Northampton, MA	11	246	249	258	9
Oklahoma: Sulphur	Oklahoma City, OK	19	557	552	573	21
Wisconsin: King	Madison, WI	3	254	256	260	4

[1] Based on the number of patient days during the fiscal year divided by the number of days in the fiscal year.

[2] Includes deaths.

[3] Discharges and deaths during the fiscal year plus the number of patients on the rolls at the end of the fiscal year.

[4] Total on rolls (bed occupants and patients on leave of absence.)

AMBULATORY CARE

TABLE 44

Outpatient Medical Program: Visits to VA Staff and Private Physicians on a Fee-For-Service Basis—Fiscal Years 1970—1979

Fiscal Year	Purpose of Visit											
	All Purposes			Examinations for Compensation for Pension Purposes			Examinations to Determine Need for Medical Care			All Other Purposes		
	Total	Staff	Fee	Total	Staff	Fee	Total	Staff	Fee	Total	Staff	Fee
1979 ..	17,262,408	15,053,332	2,209,076	372,077	290,695	81,382	2,239,313	2,213,770	25,543	14,651,058	12,548,907	2,102,151
1978 ..	17,416,275	15,069,573	2,346,702	405,301	321,372	83,929	2,244,929	2,227,915	17,014	14,766,045	12,520,295	2,245,750
1977 ..	17,045,079	14,675,294	2,369,785	421,425	337,252	84,173	2,205,165	2,193,258	11,907	14,418,489	12,144,774	2,273,715
1976 ..	16,409,850	14,222,804	2,187,046	388,674	345,152	43,522	2,126,614	2,124,362	2,252	13,894,562	11,753,290	2,141,272
1975 ..	14,929,517	12,895,514	2,034,003	353,590	323,085	30,505	1,951,618	1,948,907	2,711	12,324,309	10,323,522	2,000,787
1974 ..	12,266,476	10,457,830	1,808,646	316,359	290,728	25,631	1,692,876	1,691,695	1,181	10,257,241	8,475,407	1,781,834
1973 ..	10,858,491	9,165,094	1,693,397	339,557	310,686	28,871	1,577,282	1,576,143	1,139	8,941,652	7,278,265	1,663,387
1972 ..	9,526,881	7,930,080	1,596,801	406,065	342,035	64,030	1,494,491	1,492,548	1,943	7,626,325	6,095,497	1,530,828
1971 ..	8,064,092	6,798,146	1,265,946	456,302	369,911	86,391	1,373,368	1,371,340	2,028	6,234,422	5,056,895	1,177,527
1970 ..	7,311,894	6,135,633	1,176,261	390,100	336,383	53,717	1,222,591	1,221,124	1,467	5,699,203	4,578,126	1,121,077

AMBULATORY CARE

TABLE 45

Outpatient Dental Care: Applications for Care (Eligibility Classes I-VI) [1] Fiscal Years 1970—1979

Fiscal Year	Pending Fee Case Load Beginning of Year	Received During The Year	Total	Dispositions During The Year	Pending Fee Case Load At End of Year
1979	40,751	191,308	232,059	194,778	37,281
1978	36,096	197,338	233,434	192,683	40,751
1977	40,254	216,863	257,117	221,021	36,096
1976	45,910	233,392	279,302	241,003	38,299
1975	41,611	239,182	280,793	234,883	45,910

[1] As provided for in Title 38 USC, Sec. 612, and VA Regulations 6120-6129.

AMBULATORY CARE

TABLE 46

Outpatient Dental Care: Workload by VA Staff and on a Fee-For-Service Basis—Fiscal Years 1970—1979

Fiscal Year	VA Staff		Non-VA Dentists on a Fee-for-Service Basis		
	Examinations Completed	Treatment Cases Completed	Examinations Completed	Treatment Cases Completed	Net Cases Authorized
1979	129,185	134,769	....	....	89,848
1978	127,278	127,167	....	....	110,081
1977	107,987	109,308	....	....	107,285
1976	93,230	94,097	....	....	121,958
1975	85,802	83,870	....	....	130,881
1974	79,674	79,488	.... [1]	.... [1]	156,467
1973	114,189	82,916	113,579	166,472	....
1972	142,919	82,873	113,819	166,819	....
1971	147,794	82,724	91,580	145,864	....
1970	131,542	81,110	40,348	94,890	....

[1] Reporting of fee-basis workload changed to the net number of cases authorized by VA.

Pharmacy Activity—Fiscal Years 1978–1979

Activity	FY 1979	FY 1978
VA Pharmacies		
Prescriptions dispensed – Total	35,821,814	34,165,664
Inpatient	1,991,569	1,999,278
Ambulatory – Total	33,830,245	32,166,386
Methadone	1,129,648	1,291,637
All other	32,700,597	30,874,749
Investigational drugs dispensed	71,692	66,932
Doses dispensed		
Ward stock system	174,557,989	192,427,074
Automatic replenishment system	124,693,851	123,601,679
External medications	94,578,887	93,665,911
Orders for substances controlled by the Drug Enforcement Administration	37,870,091	40,932,573
Unit doses	67,846,143	47,138,356
Primary intravenous admixtures	1,117,887	1,010,693
Secondary intravenous admixtures ("piggy backs")	2,633,531	2,170,234
Hyperalimentation	328,966	267,525
Fluids and sets	5,967,143	5,334,091
Blood and blood products	184,652	197,349
Fee-Basis		
Prescriptions filled by participating pharmacies	1,057,358	1,060,646

CONSTRUCTION

TABLE 40

Replacement and Relocation Hospital Construction Projects, Fiscal Year 1979—Completions And Year End Status

Location		Total Number of Beds and Hospital Type[1]	Estimated Construction Cost[2]	Value of Work in Place	Percent Complete[3]	Date Construction Completed (C)[4] or Contract Awarded (A)
TOTAL	11 Projects	6407	976,117,000	172,666,000	18	
A. Projects Completed in Fiscal Year 1979						
Total	0 Projects	–0–	–0–	–0–	–0–	
B. Projects Under Construction 9/30/79						
Total	6 Projects	3662	453,228,000	172,666,000	38	
Florida : Bay Pines		830	101,881,000	6,211,000	6	August 1978 (A)
Georgia : Augusta		420	39,463,000	36,064,000	91	June 1978 (A)
New York : Bronx		702	108,242,000	86,864,000	80	June 1974 (A)
South Carolina : Columbia		400	26,500,000	25,419,000	96	December 1975 (A)
Virginia : Richmond		820	109,500,000	13,213,000	12	November 1976 (A)
West Virginia : Martinsburg		490	67,532,000	4,886,000	7	July 1977 (A)
C. Projects Authorized – Not Under Construction 9/30/79[7]						
Total	5 Projects	2745	522,889,000			
Arkansas : Little Rock		490 (General)				
Maryland : Baltimore		400 (General)				
New Jersey : Camden		480 (General)				
Oregon : Portland		860 (General)				
Washington : Seattle		515 (General)				

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[1] *Included receiving, recovery and Nursing Home Care Beds and Spinal Cord Injury Beds.*

[2] *Construction anticipated, issued, awarded, including contingencies.*

[3] *Based on general construction only.*

[4] *Major general construction contract completed. Minor Construction and Landscaping may remain to be accomplished.*

[5] *Same as value of construction issued or awarded when project is financially complete.*

[6] *Under Construction when major general construction contract has been awarded.*

[7] *Authorized when funds are appropriated for construction, technical services, or site acquisition.*

CONSTRUCTION

TABLE 40

Modernization Construction Projects,[1]—Fiscal Year 1979—Completions and Year End Status

Location	Description	Estimated Construction Cost	Value of Work in Place	Percent Complete	Date Construction Complete (C) or Contract Awarded (A)
TOTAL	9 Projects	43,472,656	21,693,331	50	
A. Projects Completed, Total	4 Projects	14,544,053	14,544,053	100	
New York : St. Albans	Modernization – Pharmacy	327,496	[2]	100	December 1978 (C)
Ohio : Chillicothe	Modernization of Bldgs. #30 & 31	2,904,291	[2]	100	May 1979 (C)
Virginia : Hampton	Modnze & A/C Bsmt/Nursing Units Bldg 110	1,466,413	[2]	100	July 1979 (C)
Wisconsin : Madison	New Wing Addition	9,845,853	[2]	100	May 1979 (C)
B. Projects Under Construction, Total	3 Projects	8,144,603	7,149,278	88	
Projects $1,000,000 and Over, Total	2 Projects	7,299,069	6,321,130	87	
New York : St. Albans	Modernization Out Patient Clinic (west)	1,015,000	210,685	21	June 1978 (A)
Ohio : Chillicothe	Modernization of Bldg. #7, 26 & 27	6,284,069	6,110,445	97	September 1977 (A)
Projects Under $1,000,000, Total	1 Project	845,534	828,148	98	
C. Projects Not Under Construction, Total	2 Projects	20,784,000			
Projects $1,000,000 and Over, Total	2 Projects	20,784,000			
Kansas : Wichita	Modernization-Alters & Addition (Phase 1)	5,532,000			
Massachusetts : West Roxbury	SCI Center & Modernize Bldg. #1 (PH2)	15,252,000			
Projects under $1,000,000, Total	0 Project				

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[1] *Projects included in table if approved for development by Administrator's Office or if there has been an appropriation of funds available for financing all or part of the project.*

[2] *Same as value of construction issued or awarded when project is financially complete.*

[3] *For Purchase & Hire Projects, the date the station reports construction started.*

TABLE 50

CONSTRUCTION

Nursing Home Care Units Construction Projects,[1]—Fiscal Year 1979—
Completions and Year End Status

Location	Projects	Number of Nursing Home Care Beds	Estimated Construction Cost	Value of Work in Place	Percent Complete	Date Construction Completed (C) or Contract Awarded (A)[3]
TOTAL	16 Projects	1,590	77,186,711	19,287,998	25	
A. Projects Completed, Total	2 Projects	200	5,394,208	5,394,208	100	
California : Palo Alto (NPD)		150	4,808,564	[2]	100	May 1979 (C)
Kentucky : Lexington (LD)		50	585,644	[2]	100	March 1979 (C)
B. Projects Under Construction, Total	10 Projects	1,030	39,032,403	13,893,790	36	
Projects $1,000,000 and Over, Total	9 Projects	1,000	38,447,623	13,893,790	36	
California : Livermore		120	6,524,000	…………	……	September 1979 (A)
Florida : Gainesville		120	4,734,000	…………	……	September 1979 (A)
: Miami	& Energy Conservation	120	4,985,294	3,164,251	64	May 1978 (A)
Maryland : Perry Point		90	2,438,440	285,274	16	October 1978 (A)
: Perry Point		80	2,449,426	1,115,013	44	October 1978 (A)
South Carolina : Columbia		120	3,575,185	3,384,583	95	September 1977 (A)
Tennessee : Memphis	& Energy Conservation	120	5,029,031	1,841,835	33	October 1978 (A)
Texas : Temple		120	4,032,000	…………	……	September 1979 (A)
Virginia : Hampton	& Energy Conservation	120	4,726,337	4,192,734	89	February 1977 (A)
Projects Under $1,000,000, Total	1 Project	30	584,780	…………	……	
C. Projects Not Under Construction, Total	4 Projects	360	32,760,100			
Projects $1,000,000 and Over, Total	3 Projects	360	31,945,300			
Dist. of Columbia : Washington		120	20,945,000			
Georgia : Atlanta		120	5,918,000			
Pennsylvania : Wilkes Barre		120	5,082,300			
Projects Under $1,000,000, Total	1 Project	N/S	814,800			

[1] Projects included in table if approved for development by Administrator's Office or if there has been an appropriation of funds available for financing all or part of the project.

[2] Same as value of construction issued or awarded when project is financially complete.

[3] For Purchase & Hire Projects, the date the station reports construction started.

TABLE 51

CONSTRUCTION

Research and Education Construction Projects,[1]—Fiscal Year 1979
Completions and Year End Status

Location	Type	Estimated Construction Cost	Value of Work in Place	Percent Complete	Date Construction Complete (C) or Contract Awarded (A)
TOTAL	17 Projects	29,451,586	12,375,793	42	
A. Projects Completed, Total	3 Projects	10,582,162	10,582,162	100	
Mississippi : Jackson	Research and Education Addition	5,707,202	[2]	100	November 1978 (C)
New York : Albany	Education & Training Facilities (Ph-2)	364,130	[2]	100	October 1978 (C)
Texas : Dallas	Research & Education Addition	4,510,830	[2]	100	December 1978 (C)
B. Projects Under Construction, Total	6 Projects	5,502,324	1,793,631	33	
Projects $1,000,000 and Over, Total	2 Projects	2,350,910	832,785	35	
Arizona : Tucson	Animal Research Facility	1,158,063	832,785	72	October 1978 (A)
California : Fresno	Area Health Education Center	1,192,847	…………	……	September 1979 (A)
Projects Under $1,000,000, Total	4 Projects	3,151,414	960,846	30	
C. Projects Not Under Construction, Total	8 Projects	13,367,100			
Projects $1,000,000 and Over, Total	3 Projects	9,679,000			
Florida : Miami	Research & Educ. Bldg. & Psych. Addn.	7,073,000			
Louisiana : Shreveport	Alterations for Research & Education	1,200,000			
Pennsylvania : Philadelphia	Adm/Educ. Relocation for Clinical Improve	1,406,000			
Projects Under $1,000,000, Total	5 Projects	3,688,100			

[1] Projects included in table if approved for development by Administrator's Office or if there has been an appropriation of funds available for financing all or part of the project.

[2] Same as value of construction issued or awarded when project is financially complete.

[3] For Purchase & Hire Projects, the date the station reports construction started.

Other Improvement Construction Projects,[1] Fiscal Year 1979—Completions And Year End Status

Location	Description	Estimated Construction Cost	Value of Work in Place	Percent Complete	Date Construction Completed (C) or Contract Awarded (A)
1. AIR CONDITIONING CONSTRUCTION PROJECTS					
TOTAL	16 Projects	115,228,830	52,264,402	46	
A. Projects Completed, Total	7 Projects	31,534,330	31,534,330	100	
California : Sepulveda		11,983,685	[3]	100	November 1978 (C)
Kentucky : Lexington		6,875,549	[3]	100	March 1979 (C)
Mississippi : Biloxi (GD)		319,190	[3]	100	March 1979 (C)
Missouri : Poplar Bluff		3,852,216	[3]	100	October 1978 (C)
Nebraska : Lincoln		3,344,246	[3]	100	February 1979 (C)
Virginia : Salem		294,400	[3]	100	February 1979 (C)
: Salem		4,865,634	[3]	100	July 1979 (C)
B. Projects Under Construction, Total	9 Projects	48,010,500	20,730,072	43	
Projects $1,000,000 and Over, Total	6 Projects	46,421,282	19,411,812	42	
Arkansas : Fayetteville		4,027,711			September 1979 (A)
Iowa : Knoxville		8,993,719	576,396	6	May 1979 (A)
Indiana : Indianapolis		3,713,583	3,484,899	94	January 1978 (A)
Maryland : Perry Point		8,294,950	7,583,863	91	May 1977 (A)
Pennsylvania : Coatesville	Energy/Conservation	14,219,518	1,035,322	7	December 1978 (A)
: Lebanon		7,171,781	6,729,332	94	October 1977 (A)
Projects Under $1,000,000, Total	3 Projects	1,589,218	1,318,260	83	
C. Projects Not Under Construction, Total	2 Projects	35,784,000	....	......	
Projects $1,000,000 and Over, Total	2 Projects	35,784,000	....	......	
New Jersey : East Orange		29,465,000	....	......	
New York : Castle Point		6,319,000	....	......	
2. OTHER IMPROVEMENTS – CONSTRUCTION PROJECTS					
TOTAL	721 Projects	496,400,290	94,815,161	19	
A. Projects Completed, Total	163 Projects	66,925,823	66,925,823	100	
Alabama : Birmingham	Replace Fire Alarm System	406,909	[3]	100	May 1979 (C)
: Birmingham	25 Bed Respiratory Care Unit	487,176	[3]	100	June 1979 (C)
: Birmingham	Smoke Barriers	228,185	[3]	100	October 1978 (C)
: Birmingham	6 Bed Surgical Intensive Care Unit	250,349	[3]	100	September 1979 (C)
: Tuscaloosa	Renovate Ward 1C West - Bldg. # 1	296,816	[3]	100	October 1978 (C)
: Tuskegee	Emergency Generator	737,296	[3]	100	March 1979 (C)
Arizona : Prescott	Deadend Corridor Stairs	660,734	[3]	100	July 1979 (C)
: Prescott	Expand Surgical Suite (Phase 1)	27,989	[3]	100	December 1978 (C)
California : Brentwood	Occupational Therapy - Bldg. #208	127,290	[3]	100	June 1979 (C)
: Livermore	Smoke Barriers	87,321	[3]	100	June 1979 (C)
: Long Beach	Sprinkler System	539,288	[3]	100	August 1979 (C)
: Long Beach	Outpatient Clinic Expansion	5,569,151	[3]	100	February 1979 (C)
: Martinez	Update Catheterization Lab	281,926	[3]	100	November 1978 (C)
: Palo Alto (PAD)	Core Laboratories G.R.E.C.C.	328,329	[3]	100	November 1978 (C)
: San Diego	Improvements to Outpatient Clinic	478,836	[3]	100	January 1979 (C)
: San Diego	Renov. & Expand Psy/Alcoholic Nursing Unit	174,848	[3]	100	May 1979 (C)
: Sepulveda	Radiology Expansion	452,048	[3]	100	April 1979 (C)
Colorado : Denver	Sprinkler System	194,516	[3]	100	May 1978 (C)
: Denver	Ionization Detector	218,444	[3]	100	May 1979 (C)
: Denver	Remodel 7th Floor - Psy Ward	260,430	[3]	100	September 1979 (C)
: Denver	Centralized 21 Bed RCU with Monitored Beds	244,600	[3]	100	August 1979 (C)
: Grand Junct.	Ambulatory Care Service, Bldg. #1	270,987	[3]	100	May 1979 (C)
: Grand Junct.	Remodel Lab. & Canteen Service	1,017,335	[3]	100	May 1979 (C)
: Grand Junct.	Remodel Bldg. #5 for Admin.	270,232	[3]	100	May 1979 (C)
Connecticut : Newington	Purchase State Owned Bldg. for Lab.	182,000	[3]	100	February 1979 (C)
: West Haven	Renovate Processing & Distribution	433,309	[3]	100	March 1979 (C)
: West Haven	Improvements to Outpatient Clinic	780,260	[3]	100	March 1979 (C)
District of Columbia : Washington	Upgrade Cardiac Catheterization Lab	115,816	[3]	100	July 1979 (C)
Florida : Gainesville	Research Lab	185,143	[3]	100	July 1979 (C)
: Miami	Rearrange Main Kitchen	230,282	[3]	100	August 1979 (C)
Georgia : Dublin	14 Bed Respiratory Care Center	395,250	[3]	100	October 1978 (C)
Iowa : Des Moines	Respiratory Care Center	134,335	[3]	100	July 1979 (C)
: Des Moines	Addn. to Bldg. #1 Dental Exp. & Recovery	895,423	[3]	100	July 1979 (C)
: Des Moines	Upgrade Emergency Power	432,081	[3]	100	November 1978 (C)
: Iowa City	Replace Boiler Plant & Deadend Corr. Str.	2,462,235	[3]	100	October 1978 (C)
: Iowa City	Expand Surgical	572,980	[3]	100	May 1979 (C)
: Knoxville	Enclose 4 Porches Bldg. #102	98,611	[3]	100	January 1979 (C)
: Knoxville	Replace Fire Alarm System	178,780	[3]	100	November 1978 (C)
Illinois : Chicago (Lake)	Install Emergency Generator	768,253	[3]	100	May 1979 (C)
: Hines	Smoke Door Holders	440,625	[3]	100	June 1979 (C)
: Hines	Electrical Distribution System	238,284	[3]	100	June 1979 (C)
: Marion	Deadend Corridor Stairs	260,047	[3]	100	June 1979 (C)

See footnotes at end of table

Other Improvement Construction Projects,[1] Fiscal Year 1979—Completions And Year End Status—Continued

Location		Description	Estimated Construction Cost	Value of Work in Place	Percent Complete	Date Construction Completed (C) or Contract Awarded (A)
Indiana	: Ft. Wayne	Nursing Home Care Unit Addn. - 14 Bed	329,256	[3]	100	October 1978 (C)
	: Ft. Wayne	Expand Outpatient and Admitting	270,071	[3]	100	October 1978 (C)
	: Marion	Warehouse Addition to Bldg. #65	567,576	[3]	100	July 1979 (C)
	: Marion	Replace Fire Alarm System	444,149	[3]	100	March 1979 (C)
Kansas	: Leavenworth	Install Zone Heating Controls	217,433	[3]	100	December 1978 (C)
	: Leavenworth	Emergency Gen. & Cor. of Elect. Defs.	699,064	[3]	100	December 1978 (C)
	: Leavenworth	Utility Access Walkways Bldg. #88, 89 & 91	520,224	[3]	100	August 1979 (C)
	: Topeka	Deadend Corridor Stairs	142,896	[3]	100	January 1979 (C)
Kentucky	: Lexington (LD)	Emergency Generator	218,490	[3]	100	March 1979 (C)
	: Lexington (LD)	Correction of Electrical Deficiencies	500,810	[3]	100	March 1979 (C)
	: Lexington (UD)	Relocate Nuclear Medicine	183,240	[3]	100	February 1979 (C)
	: Louisville	Relocate/Renovate Clinics	181,887	[3]	100	May 1979 (C)
Louisiana	: Alexandria	Renovate Dietetics - Building #4	252,261	[3]	100	January 1979 (C)
	: Alexandria	Electrical Distribution System	712,363	[3]	100	November 1978 (C)
Massachusetts	: Bedford	Deadend Corridor Stairs	581,781	[3]	100	March 1979 (C)
	: Bedford	Connect to City Sewer System	298,444	[3]	100	October 1978 (C)
	: Bedford	Emergency Generator	1,018,628	[3]	100	April 1979 (C)
	: Bedford	New Exit - Building #2	201,618	[3]	100	March 1979 (C)
	: Brockton	Emergency Generator	234,374	[3]	100	September 1979 (C)
	: Northampton	Expansion Outpatient Clinic	2,085,078	[3]	100	May 1979 (C)
Maine	: Togus	Emergency Generators	187,279	[3]	100	March 1979 (C)
Michigan	: Battle Creek	Dental Expansion	372,085	[3]	100	February 1979 (C)
	: Battle Creek	Install Insulation in Bldg. Attics	146,390	[3]	100	May 1979 (C)
	: Battle Creek	Patient Privacy Rooms - Bldgs. #9, 10 & 12	246,618	[3]	100	March 1979 (C)
	: Saginaw	Construct New Lab	222,272	[3]	100	November 1978 (C)
Minnesota	: Minneapolis	Replace Fire Alarm System	321,899	[3]	100	November 1978 (C)
	: St. Cloud	Remodel Westend Bldg. #1-H	283,000	[3]	100	April 1979 (C)
	: St. Cloud	Lath/Plastering Bldg. 1H Westend	24,485	[3]	100	January 1979 (C)
	: St. Cloud	Remodel Westend Second Flr. Bldg. #1	179,300	[3]	100	April 1979 (C)
Missouri	: Kansas City	Cardio/Diagnostic Lab	84,418	[3]	100	April 1979 (C)
	: Kansas City	Remodel Nursing Station	184,086	[3]	100	October 1978 (C)
	: Poplar Bluff	Relocate Dental Clinic	153,043	[3]	100	May 1979 (C)
	: Poplar Bluff	Audio Visual Call System	128,850	[3]	100	October 1978 (C)
	: Poplar Bluff	Replace Fire Alarm System	67,300	[3]	100	October 1978 (C)
	: Poplar Bluff	Smoke Barriers	341,700	[3]	100	October 1978 (C)
	: Poplar Bluff	Additional Exits	371,100	[3]	100	October 1978 (C)
	: St. Louis (JB)	Emergency Power	467,838	[3]	100	December 1978 (C)
	: St. Louis (JB)	Relocate OI Inhalation Therapy	91,307	[3]	100	March 1979 (C)
Mississippi	: Biloxi (BD)	Additional Exits 8-5	48,522	[3]	100	May 1979 (C)
	: Biloxi (BD)	6 Bed Surgical Intensive Care - Bldg. #1	146,284	[3]	100	July 1979 (C)
	: Biloxi (GD)	Additional Exits, Bldgs. #41, 59 & 62	452,844	[3]	100	May 1979 (C)
	: Jackson	Remodel Patient 16 Bed Wards	298,812	[3]	100	June 1979 (C)
	: Jackson	Remodel & Relocate MICU/CCU	346,889	[3]	100	July 1979 (C)
Montana	: Ft. Harrison	Temperature Controls Building #141	125,373	[3]	100	March 1979 (C)
	: Ft. Harrison	Upgrade & Extend Fire Alarm System	129,768	[3]	100	October 1978 (C)
North Carolina	: Asheville	Expand Canteen Storage & Offices	129,845	[3]	100	August 1979 (C)
	: Asheville	Modify Nurse Servers	181,872	[3]	100	February 1979 (C)
	: Durham	Warehouse Admin. Bldg. #1 (Clinic Exp. Move)	253,010	[3]	100	April 1979 (C)
	: Fayetteville	Ambul. Health Care Facil. Expansion	82,434	[3]	100	July 1979 (C)
	: Fayetteville	Relocate/Consolidate Rehab. Medicine Svc.	229,885	[3]	100	January 1979 (C)
North Dakota	: Fargo	Additional Parking for Education	343,020	[3]	100	January 1979 (C)
	: Fargo	Correct Electrical Deficiencies	751,117	[3]	100	April 1979 (C)
	: Fargo	Additional Bldg. 38 Engineering Functions	224,447	[3]	100	May 1979 (C)
New Jersey	: Lyons	Relocate Clinical Lab	150,573	[3]	100	February 1979 (C)
	: Lyons	Relocate Clinical Lab Bldg. #1-G	52,527	[3]	100	October 1978 (C)
	: Lyons	Relocate Clinical Lab Bldg. #1	13,751	[3]	100	November 1978 (C)
New Mexico	: Albuquerque	Lab Remodeling - Phase 2	251,273	[3]	100	February 1979 (C)
Nevada	: Reno	Purchase Leased Facility	212,890	[3]	100	September 1979 (C)
	: Reno	Remodel NE Wing Ward 2B	218,583	[3]	100	June 1979 (C)
New York	: Batavia	Deadend Corridor Stairs	346,980	[3]	100	July 1979 (C)
	: Bath	Install Thermal Insulation	48,000	[3]	100	January 1979 (C)
	: Bath	New Warehouse	606,215	[3]	100	March 1979 (C)
	: Canandaigua	Relocate & Renovate PAD	473,820	[3]	100	December 1978 (C)
	: Canandaigua	New Engineer Shops & Office Bldg.	1,206,868	[3]	100	March 1979 (C)
	: New York	Smoke Door Holders	261,740	[3]	100	May 1979 (C)
	: New York	Relocate Pharmacy	149,876	[3]	100	April 1979 (C)
Ohio	: Cincinnati	Outpatient Clinic Expansion/Addition	3,980,544	[3]	100	December 1978 (C)
	: Cincinnati	Elevator, Porch Enclosure & Loading Dock	118,500	[3]	100	May 1979 (C)
	: Cincinnati	Deadend Stairwell - Bldg. #84	185,187	[3]	100	May 1979 (C)
	: Cleveland (WP)	Expand Hemodialysis 4 Beds	189,208	[3]	100	April 1979 (C)
	: Chillicothe	20 Bed RCC, Plum. Funct. Lab & 6 BE	501,247	[3]	100	May 1979 (C)
	: Dayton	Remodel Ward #12	561,119	[3]	100	May 1979 (C)
	: Dayton	Additional Transformer & Switchgear B300	266,706	[3]	100	October 1978 (C)
Oklahoma	: Muskogee	Safety & Fire Deficiencies (Phase 1)	400,403	[3]	100	August 1979 (C)
	: Oklahoma City	Fire Barrier Penetration	282,003	[3]	100	December 1978 (C)
Oregon	: Portland	Emergency Circuits	125,000	[3]	100	March 1979 (C)
	: Portland	Research Bldg. #1	277,935	[3]	100	August 1979 (C)
	: White City	Renovate B-213 North	306,194	[3]	100	July 1979 (C)
	: White City	Corr. Def. in Clinical Support Facilities	312,884	[3]	100	October 1978 (C)
Pennsylvania	: Butler	40 Bed Resp. Care & Pulm. Funct.	581,051	[3]	100	May 1979 (C)
	: Lebanon	Smoke Barrier Doors	208,046	[3]	100	August 1979 (C)
	: Lebanon	Nurse Call System	188,379	[3]	100	September 1979 (C)
	: Pittsburgh	Install X-Ray in Outpatient Area	43,487	[3]	100	January 1979 (C)

See footnotes at end of table

Other Improvement Construction Projects,¹ Fiscal Year 1979—Completions And Year End Status—Continued

Location		Description	Estimated Construction Cost	Value of Work in Place	Percent Complete	Date Construction Completed (C) or Contract Awarded (A)
Puerto Rico	San Juan	Additional A/C Units	449,828	0	100	August 1979 (C)
	San Juan	Install Load Management System	111,779	0	100	July 1979 (C)
Rhode Island	Providence	Sprinkler System	312,380	0	100	March 1979 (C)
South Carolina	Charleston	Animal Research Facility 2nd Floor	231,336	0	100	August 1979 (C)
	Charleston	Education Space Existing Roof Area	330,000	0	100	December 1978 (C)
	Charleston	Research Space Existing Roof Area	342,079	0	100	January 1979 (C)
	Columbia	Deadend Corridor Stairs	189,761	0	100	September 1979 (C)
South Dakota	Hot Springs	Upgrade Electrical System	848,242	0	100	April 1979 (C)
	Hot Springs	Surgery/PAD Alterations	1,078,799	0	100	March 1979 (C)
	Sioux Falls	Medical Research Building	205,790	0	100	December 1978 (C)
	Sioux Falls	Remodel Surgery	311,334	0	100	December 1978 (C)
Tennessee	Memphis	Modify Nurse Servers	157,830	0	100	October 1978 (C)
	Mountain Home	Install Incinerator 2/Heat Rec. System	180,570	0	100	September 1979 (C)
	Murfreesboro	20 Bed Stroke Rehabilitation Unit	338,000	0	100	November 1978 (C)
	Nashville	4 Bed Coronary Care Unit	84,820	0	100	December 1978 (C)
Texas	Big Spring	Renovate Lab. 2nd. Floor	191,100	0	100	August 1979 (C)
	Big Spring	6 Bed Surgical Intensive Care Unit	123,985	0	100	July 1979 (C)
	Bonham	Deadend Corridor Stairs	865,737	0	100	July 1979 (C)
	Dallas	Relocate Rehabilitation Medicine	211,043	0	100	February 1979 (C)
	Dallas	Installation of Medical Gas System	730,860	0	100	November 1978 (C)
	San Antonio	Smoke Exhaust Fans	210,839	0	100	July 1979 (C)
	San Antonio	Expand Outpatient	202,489	0	100	July 1979 (C)
	Temple	Correction of Electrical Deficiencies	524,342	0	100	March 1979 (C)
Utah	Salt Lake	Energy Retrofit Units	108,400	0	100	September 1979 (C)
	Salt Lake	Seismic Corrections, Bldg 6-10, 13, 27 & 28	2,183,320	0	100	April 1979 (C)
Virginia	Salem	Additional Elevator, Bldg. 46	155,600	0	100	January 1979 (C)
	Salem	Renovate Building 46	737,500	0	100	February 1979 (C)
	Salem	Renovate Bldg. #77 for Intermediate Care	1,184,380	0	100	February 1979 (C)
Washington	American Lake	8 Bed OP ICU	159,890	0	100	August 1979 (C)
	Seattle	Pre-Engineered Recreation Bldg.	54,000	0	100	November 1978 (C)
	Seattle	Laboratory Expansion	284,201	0	100	November 1978 (C)
	Spokane	Replace Fire Alarm System	111,617	0	100	October 1978 (C)
	Spokane	Correction of Fire & Safety Deficiencies	248,060	0	100	December 1978 (C)
Wisconsin	Tomah	Update Elect. Dist. Sys. & Auxil. Elect. Ph.2	702,889	0	100	June 1979 (C)
	Tomah	Update Elect. Dist. Sys. & Auxil. Elect. Ph.1	1,080,000	0	100	February 1979 (C)
	Wood	Ambulatory Care Relocation	296,107	0	100	June 1979 (C)
	Wood	Relocate Cardio-Cath Lab	141,144	0	100	September 1979 (C)
West Virginia	Beckley	Emergency Generator	96,740	0	100	June 1979 (C)
B. Projects Under Construction, Total		360 Projects	256,229,962	94,615,161	36	
Projects $1,000,000 and Over, Total		35 Projects	159,015,837	50,540,588	34	
Alabama	Tuscaloosa	Renovate Dietetics	1,370,460	....	....	March 1979 (A)
California	Fresno	Outpatient Clinic Addition	3,473,000	....	....	September 1979 (A)
	Long Beach	Emergency Generator	1,001,131	105,831	10	September 1978 (A)
	Palo Alto	Emergency Generator & Update Power System	1,348,000	267,139	20	June 1978 (A)
Georgia	Augusta (LD)	Dietary & Food Prep. Fac. (Energy Conserv)	3,138,058	1,583,718	51	December 1978 (A)
	Augusta (LD)	New Boiler & Steam Gen. & Energy/Conserv	2,756,140	983,279	35	February 1979 (A)
Iowa	Knoxville	Emergency Gen. & Electrical Deficiencies	1,104,820	....	....	September 1979 (A)
Illinois	Chicago (LA)	Remodel Surgical Area	1,730,071	1,545,333	89	August 1977 (A)
	North Chicago	Electrical Distribution	2,610,000	....	....	September 1979 (A)
Indiana	Indianapolis	Emergency Generator & Electrical Defs.	1,388,824	1,086,751	78	October 1978 (A)
	Indianapolis	Clinical Improvements & Education	9,375,734	5,070,453	54	July 1978 (A)
	Marion	Correct Electrical Deficiencies	1,438,337	983,348	68	August 1978 (A)
Massachusetts	Brockton	Modern. Patient Rooms Bldgs #3 & 5	1,040,313	882,848	84	September 1978 (A)
Maryland	Perry Point	Correction of Electrical Defs.	1,403,061	1,238,329	91	May 1977 (A)
Maine	Togus	Clinical Improvements	1,105,371	980,331	86	September 1977 (A)
Mississippi	Jackson	Update R/O Space for Outpatient Clinic	2,195,849	712,383	32	January 1979 (A)
North Carolina	Durham	Electrical Deficiencies	1,195,780	1,094,931	91	May 1978 (A)
Nebraska	Grand Island	Emergency Gen. & Electrical Defs.	1,017,000	....	....	September 1979 (A)
New Jersey	East Orange	Emergency Gen. & Corr. Elect. Defs.	2,045,180	1,052,138	52	March 1977 (A)
Nevada	Reno	Clinical Addn., Utility Improv. Boiler Pl.	11,557,285	2,116,790	18	December 1978 (A)
New York	Buffalo	Outpatient Clinic Expansion	9,060,000	4,517,775	50	March 1977 (A)
	Syracuse	Correction of Electrical Deficiencies	1,000,000	74,150	70	November 1978 (A)
Ohio	Dayton	Clinical Addition & Energy Conservation	8,870,401	4,791,021	53	April 1978 (A)
Rhode Island	Providence	SPC/Admission Consolidation & Pathology	3,063,273	2,839,360	87	September 1977 (A)
South Dakota	Sioux Fall	New Boiler Plant	2,184,960	....	....	September 1979 (A)
Tennessee	Nashville	Ambulatory Care, Research & Education Addn.	11,487,241	1,084,910	9	January 1979 (A)
Texas	Waco	Boiler Plant Replacement	1,400,000	1,218,000	87	June 1978 (A)
Utah	Salt Lake City	Seismic Corrections, Bldgs 1 thru 5	5,937,085	5,704,461	96	October 1977 (A)
	Salt Lake City	Clinic & AMB Care Addn. Lib. Addn. & R&E	20,217,060	....	....	September 1979 (A)
Virginia	Salem	New Clinical Building	2,862,739	2,480,384	86	December 1978 (A)
	Salem	Emergency Electrical Power System	1,488,045	....	....	December 1978 (A)
Vermont	White River Jct	Ambulatory Care Addition	3,216,700	....	....	September 1979 (A)
Wisconsin	Wood	Emergency Generator & Electrical Defs.	1,330,000	....	....	September 1979 (A)
West Virginia	Huntington	Addition to Building #1 Phase I	6,500,862	1,710,876	26	March 1979 (A)
Washington	American Lake	Additional Exits	1,018,000	980,110	96	June 1979 (A)
Projects Under $1,000,000, Total		325 Projects	97,213,145	44,074,573	38	

See footnotes at end of table.

Other Improvement Construction Projects,[1] Fiscal Year 1979—Completions And Year End Status—Continued

Location		Description	Estimated Construction Cost	Value of Work in Place	Percent Complete	Date Construction Completed (C) or Contract Awarded (A)
C. Projects Not Under Construction, Total		201 Projects	400,499,345			
Projects $1,000,000 and Over, Total		71 Projects	310,425,852			
Alabama	Birmingham	Deadend Corridor Stairs	1,610,000			
	Birmingham	Blind & Low Vision Center & Eye Clinic	2,999,000			
	Tuscaloosa	Safety & Fire Deficiencies	1,418,100			
	Tuskegee	Ambulatory Care Addition	3,500,000			
	Tuskegee	Primary Distr. & 2nd Distr. Systems	1,790,000			
Arkansas	Fayetteville	Renovate Building 4	1,102,000			
California	Brentwood	Remodel Building 209 Psy.	1,997,000			
	Fresno	Correct Seismic Deficiencies	2,400,000			
	Livermore	Remodel 5th Floor Wards Bldg. 62	1,400,000			
	Palo Alto (PAD)	Two Additional Elevators	1,134,100			
	San Francisco	Remodel Bldg 10, 4 & 200 for New Functions	23,660,000			
	Sepulveda	Safety & Fire Def.	4,411,000			
Colorado	Denver	Safety & Fire Def.	1,318,000			
District of Columbia	Washington	Ambulatory Care Addition & Renovation	3,612,000			
Florida	Gainesville	Clinical Improv. & Research & Educ. - Ph 2	10,520,000			
	Miami	Relocate Surgical Intensive Care	1,361,000			
Georgia	Atlanta	Ambulatory Care Addition	7,294,000			
	Atlanta	Warehouse and Engineering Office	1,600,000			
	Augusta (LD)	Safety and Fire Def.	1,130,000			
Iowa	Des Moines	Ambulatory Care Addition & Renovation	2,235,000			
	Knoxville	Safety & Fire Def.	1,052,000			
Idaho	Boise	Renovate Wards 2 & 4 Building 67	1,616,000			
Illinois	Chicago (Lakeside)	Correction of Electrical Def.	1,800,000			
	North Chicago	Sprinkler Systems	2,964,100			
Kentucky	Louisville	Renovate OR Rooms	1,472,000			
Maryland	Perry Point	New Clinical Administration Bldg.	1,910,000			
Maine	Togus	Safety & Fire Def.	1,023,000			
Michigan	Allen Park	Expand/Renovate Lab	1,175,000			
	Battle Creek	Replace Administration Bldg.	2,100,000			
	Battle Creek	Safety & Fire Def.	1,165,000			
Minnesota	Minneapolis	Correct Fire & Safety Def.	1,900,000			
Missouri	Kansas	A-O-V Systems	1,800,000			
	St. Louis (JB)	Safety & Fire Defs.	1,130,600			
Mississippi	Biloxi (GD)	Renovate of Building 43	4,132,600			
North Carolina	Salisbury	Deadend Corridor Stairs, Bldg 4, 10, 11 & 21	1,223,000			
New Jersey	East Orange	Deadend Corridor Stairs	1,781,700			
	East Orange	Additional Elevators	4,600,000			
New York	Brooklyn	Medical Gas System	2,600,000			
	Buffalo	Renovate SPD	1,067,000			
	Canandaigua	Renovate Patient Bldgs.	21,300,000			
	Canandaigua	Deadend Corridor Stairs	5,910,000			
	New York	Electrical Distribution	1,539,540			
	New York	Safety & Fire Def.	4,987,000			
	Northport	Safety & Fire Def.	1,050,000			
	St Albans	Primary Distr. 2nd Generator Systems	1,665,100			
	St Albans	Laundry Consolidation	2,618,100			
Ohio	Cincinnati	Correction of Fire & Safety Def.	1,090,000			
	Cincinnati	Clinical Expansion & Relocation	3,111,000			
	Dayton	Consolidate Kitchen Bldgs. 300 and 411	1,133,000			
Oklahoma	Muskogee	Safety & Fire Def. (Ph 2)	1,193,292			
	Oklahoma City	Clinical Addn./Modern/Corr. Seismic Def.	32,470,000			
	Oklahoma City	Safety & Fire Def.	1,304,000			
Pennsylvania	Lebanon	Deadend Corridor Stairs	1,244,000			
	Philadelphia	Clinical Improvements	1,080,540			
	Wilkes Barre	Three Additional Elevators	2,140,000			
Puerto Rico	San Juan	Update RO Space for Outpatient Clinic	4,320,000			
South Carolina	Charleston	Correction of Seismic Def.	8,857,000			
Tennessee	Mountain Home	Clinical Addition	9,145,000			
	Murfreesboro	Remodel Ward 5A and 5B	2,791,000			
	Murfreesboro	Safety & Fire Def.	2,821,000			
	Murfreesboro	Renovate Wards 6A and 6B	2,636,000			
Texas	Dallas	Ambulatory Care Addition & Renovation	5,874,000			
	Houston	60 Bed Spinal Cord Injury Unit	10,633,000			
	Houston	Correct Electrical Def.	2,431,000			
Virginia	Hampton	SCI Unit	4,140,000			
	Salem	Safety & Fire Def.	3,985,400			
	Salem	Renovate Bldg. 76 for Intermediate Care	2,100,000			
	Salem	Renovate Bldg. 77	3,450,000			
Projects Under $1,000,000, Total		130 Projects	90,073,493			

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[1] Projects included in table if approved for development by Administrator's Office or if there has been an appropriation of funds available for financing all or part of the project.

[2] Same as value of construction issued or awarded when projects financially complete.

[3] For purchase & Hire Projects the date the station reports construction started.

CONSTRUCTION TABLE 53

National Cemetery Projects,[1] Fiscal Year 1979—Completions and Year End Status

Location	Description	Estimated Construction Cost	Value of Work in Place	Percent Complete	Date Construction Completed (C) or Contract Awarded (A)
TOTAL	32 Projects	21,190,134	8,447,214	40	
A. Projects Completed, Total	6 Projects	6,562,999	6,562,999	100	
California : Golden Gate	Lawn Watering System	721,187	[2]	100	November 1978 (C)
: Riverside	Phase 1 Development	4,297,783	[2]	100	December 1978 (C)
Colorado : Ft. Logan	Extend Lawn Watering System	108,862	[2]	100	July 1979 (C)
Indiana : Marion	Combination Administration/Service Bldg.	204,690	[2]	100	November 1978 (C)
Kansas : Ft. Scott	Lawn Watering System	108,227	[2]	100	May 1979 (C)
New York : Calverton	38+ Acre Gravesite Development	1,138,150	[2]	100	January 1979 (C)
B. Projects Under Construction, Total	9 Projects	5,584,860	1,894,229	33	
Projects $1,000,000 and Over, Total	1 Project	2,850,250	459,700	17	
Massachusetts : Massachusetts	Develop 30 Acres/Const. Adm. & Svc. Bldg. (Ph-I)	2,850,250	459,700	17	June 1979 (A)
Projects Under $1,000,000, Total	8 Projects	2,934,310	1,439,528	49	
C. Projects Not Under Construction, Total	17 Projects	5,941,400			
Projects $1,000,000 and Over, Total	0	....			
D. Projects Under $1,000,000, Total	17 Projects	5,941,400			

[1] *Projects in table include those approved by the Administrator and those in some stage of design for construction for which funds have been approved.*

[2] *Same as value of construction issued or awarded when project is financially complete.*

GUARDIANSHIP AND VETERANS ASSISTANCE TABLE 54

Incompetent and Minor Beneficiaries Served

Fiscal Year	Total Beneficiaries	Incompetent Adults				Minors		
		Total	Type of Fiduciary			Total	Type of Fiduciary	
			State Court Appointed Fiduciaries	Federal Fiduciaries	Supervised Direct Payment		State Court Appointed	Federal Fiduciaries
1979	149,048	121,880	42,890	73,043	5,790	27,383	7,052	20,331
1978	148,891	110,187	44,750	65,030	5,389	38,704	8,184	21,520
1977	148,843	114,282	48,980	62,250	5,044	35,561	11,895	22,890
T.Q. 9/30/76	144,987	105,181	48,850	51,863	4,838	39,836	15,044	24,792
1976	141,218	100,044	49,295	46,035	4,331	41,174	16,154	25,020
1975	146,471	97,272	52,662	40,995	3,615	49,199	21,871	27,228
1974	[2] 177,880	107,835	56,329	48,618	2,880	70,314	33,954	[2] 36,468
1973	689,028	115,495	61,390	52,251	1,845	583,533	43,957	539,676
1972	730,532	114,092	64,626	48,740	717	616,440	53,941	562,499
1971	770,872	114,751	68,087	46,664	......	656,221	63,730	592,483
1970	780,053	114,741	69,844	44,897	......	671,312	68,290	603,024

[1] *This type payment first authorized in fiscal year 1972.*

[2] *Decrease represents cases where approved, close relative/custodians receive payments for the benefit of minors.*

SPECIAL ACTS TABLE 55

Death: Special Acts, Class of Beneficiary, Period of Service—Sept. 1979

Class of Beneficiary	Total			Regular Establishment		Civil War		Spanish-American War	
	Number	Monthly Value	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value
Total cases	19	375	19.74	8	21.13	3	25.00	8	18.25
Surviving Spouse alone	11	231	21.00	8	21.13	...	...	3	20.67
Surviving Spouse & children	...	...	.....	..	.....	...	.....	..	......
Children alone	8	144	18.00	..	.....	3	25.00	5	15.80
Total dependents	19	....	.....	8	.....	3	.....	8	.....
Surviving Spouses	11	....	.....	8	.....	...	.....	3	......
Children	8	....	.....	..	.....	3	.....	5	......

National Cemeteries—Location, Interments, and Status of Gravesites
September 30, 1979

National Cemetery	1979 Interments	Cumulative Gravesites Used	Gravesites Reserved	Gravesites Available[1]	Close-Out Date[2] (Fiscal Year)
Alexandria, LA	90	8,034	159	265	1987
Alexandria, VA	8	4,064	38	0	CLOSED
Alton, IL	1	460	29	6	CLOSED
Annapolis, MD	2	2,096	38	0	CLOSED
Balls Bluff, VA	0	25	0	0	CLOSED
Baltimore, MD	416	33,237	3,679	2	CLOSED
Barrancas, FL	605	11,084	606	4,583	1985
Bath, NY	132	8,839	0	299	1981
Baton Rouge, LA	14	5,011	60	0	CLOSED
Bay Pines, FL	1	4,190	1	1	CLOSED
Beaufort, SC	136	11,294	164	6,077	2000+
Beverly, NJ	421	35,796	4,404	3	CLOSED
Biloxi, MS	274	2,242	286	11,800	2000+
Black Hills, SD	313	5,716	486	96,435	2000+
Calverton, NY	5,941	8,182	0	381,680	2000+
Camp Butler, IL	258	8,041	337	13,854	2000+
Camp Nelson, KY	140	5,731	71	6,077	2000+
Cave Hill, KY	4	5,633	3	0	CLOSED
Chattanooga, TN	411	23,480	623	27,141	2000+
City Point, VA	28	5,408	84	6	CLOSED
Cold Harbor, VA	3	950	0	8	CLOSED
Corinth, MS	34	6,214	26	7,346	2000+
Crown Hill, IN	0	795	0	0	CLOSED
Culpeper, VA	257	4,136	17	5,761	2000+
Cypress Hills, NY	31	18,540	64	34	CLOSED
Danville, IL	78	8,101	0	322	1984
Danville, KY	0	383	1	2	CLOSED
Danville, VA	6	2,130	32	10	CLOSED
Dayton, OH	387	34,621	2	13,835	2000+
Fayetteville, AR	71	3,301	125	272	1985
Finn's Point, NJ	0	2,703	2	0	CLOSED
Florence, SC	68	4,386	75	53	1984
Ft. Bayard, NM	40	1,635	0	701	2000+
Ft. Bliss, TX	729	14,125	1,380	20,180	2000+
Ft. Gibson, OK	216	7,282	148	12,480	2000+
Ft. Harrison, VA	64	1,077	2	9	CLOSED
Ft. Leavenworth, KS	485	17,120	643	1,683	1982
Ft. Logan, CO	1,513	22,334	634	106,985	2000+
Ft. Lyon, CO	16	899	0	24,882	2000+
Ft. McPherson, NE	95	3,460	135	5,676	2000+
Ft. Meade, SD	0	199	0	0	CLOSED
Ft. Rosecrans, CA	431	41,940	2,471	0	CLOSED
Ft. Sam Houston, TX	1,740	35,978	3,290	8,810	1984
Ft. Scott, KS	82	2,893	105	2,982	2000+
Ft. Smith, AR	146	5,318	240	3,171	2000+
Ft. Snelling, MN	2,858	66,526	14,810	190,324	2000+
Glendale, VA	14	1,394	0	4	CLOSED
Golden Gate, CA	1,380	92,042	9,097	0	CLOSED
Grafton, WV	2	2,078	51	1	CLOSED
Hampton, VA	47	20,888	314	106	CLOSED
Hampton, VA (VAC)	0	22	0	0	CLOSED
Hot Springs, SD	0	1,481	0	1	CLOSED
Houston, TX	1,113	10,853	38	227,993	2000+
Indiantown Gap[3]	0	0	0	313,080	2000+
Jefferson Barracks, MO	2,371	60,804	2,822	110,465	2000+
Jefferson City, MO	4	1,048	76	14	CLOSED
Keokuk, IA	40	2,444	69	10,291	2000+
Kerrville, TX	0	480	0	0	CLOSED
Knoxville, TN	38	7,209	259	7	CLOSED
Leavenworth, KS	257	13,482	2	40,394	2000+
Lebanon, KY	28	1,966	24	4	1980
Lexington, KY	0	1,388	0	0	CLOSED
Little Rock, AR	398	16,413	386	2,043	1987
Long Island, NY	3,259	231,180	13,883	0	CLOSED
Los Angeles, CA	987	80,611	704	410	CLOSED
Loudon Park, MD	4	6,475	5	0	CLOSED
Marietta, GA	95	18,196	452	0	CLOSED
Marion, IN	84	4,482	0	15,809	2000+
Massachusetts[3]	0	0	0	222,800	2000+
Memphis, TN	677	38,253	867	4,838	1988
Mill Springs, KY	28	1,763	34	580	2000+
Mobile, AL	16	3,571	284	2	CLOSED
Mound City, IL	25	6,739	75	1,070	2000+
Mountain Home, TN	106	5,880	0	7,948	2000+
Nashville, TN	436	26,632	440	5,980	1986
Natchez, MS	67	4,858	61	72	1987
Nat. Memorial Cemetery of the Pacific, HI	830	26,539	984	833	1981
New Albany, IN	13	4,822	173	1	CLOSED
New Bern, NC	115	5,177	101	384	1987
Perryville, KY	0	0	0	0	CLOSED
Philadelphia, PA	63	10,300	43	0	CLOSED
Port Hudson, LA	46	8,134	22	998	2000+
Prescott, AZ	12	2,019	1	12	CLOSED

See footnotes at end of table.

National Cemeteries—Location, Interments, and Status of Gravesites
September 30, 1979—Continued

National Cemetery	1979 Interments	Cumulative Gravesites Used	Gravesites Reserved	Gravesites Available[1]	Close-Out Date[2] (Fiscal Year)
Puerto Rico, PR	746	11,593	1,433	46,300	2000+
Quantico, VA[3]	0	0	0	224,000	2000+
Quincy, IL	1	455	1	121	2000+
Raleigh, NC	130	3,588	91	1,411	1991
Richmond, VA	15	7,174	288	13	CLOSED
Riverside, CA	3,086	3,051	0	387,486	2000+
Rock Island, IL	318	10,302	307	4,120	1997
Roseburg, OR	120	2,179	5	184	1981
St. Augustine, FL	3	1,128	26	1	CLOSED
Salisbury, NC	89	14,176	73	1,310	1986
San Antonio, TX	1	3,009	30	174	CLOSED
San Francisco, CA	254	22,381	340	0	CLOSED
Santa Fe, NM	807	11,171	486	10,474	1989
Seven Pines, VA	8	1,119	2	10	CLOSED
Sitka, AK	9	584	1	90	1992
Springfield, MO	252	7,060	252	516	1985
Staunton, VA	4	837	7	2	CLOSED
Togus, ME	0	5,371	0	0	CLOSED
White City, OR	153	1,297	0	22,299	2000+
Willamette, OR	2,278	46,767	2,445	68,867	2000+
Wilmington, NC	119	4,216	72	320	1982
Winchester, VA	7	5,036	41	0	CLOSED
Wood, WI	667	19,611	1	6,199	1988
Woodlawn, NY	21	8,296	248	0	CLOSED
Zachary Taylor, KY	101	8,290	1,196	0	CLOSED
Totals	39,249	1,357,746	74,077	2,004,726	

[1] *Includes estimated gravesites in undeveloped areas.*

[2] *Cemeteries indicated as "CLOSED" will continue to make interments of eligible persons in occupied and previously reserved gravesites.*

[3] *Cemetery not opened for interments as of 9/30/79.*

[4] *Include 381 columbaria niches.*

TABLE 57

COMPENSATION AND PENSION

Disability, Death: Number of Cases, Amount, Period of Service

Period of Service	Number of Cases Sept. 1979	Average Annual Expenditure Per Case		Total Expenditures (in Thousands)	
		Sept. 1978	Sept. 1979	Fiscal Year 1979	Cumulative Through Sept. 1979
Grand total	4,769,489	1,866.49	2,116.50	10,324,260	165,391,827
Living veterans	3,240,283	2,070.29	2,331.13	7,706,660	....
Service connected	2,266,243	2,221.14	2,431.00	5,554,099	....
Retired Reserve or Emergency Officers	203	5,639.70	6,326.78	1,248	513,250
Non-service connected	973,813	1,727.49	2,097.78	2,150,306	....
Special acts	24	229.44	224.00	6	....
Deceased veterans	1,529,206	1,464.03	1,661.71	2,618,600	....
Service connected	360,668	3,131.13	3,409.96	1,216,502	....
Non-service connected	1,168,499	871.99	1,121.66	1,402,093	....
Special acts	19	261.00	236.84	5	....
Civil War	223	1,184.98	1,204.84	266	8,222,083
Deceased veterans	223	1,184.98	1,204.84	266	....
Service connected	6	3,216.00	3,642.00	22	....
Non-service connected	214	1,157.98	1,144.43	245	....
Special acts	3	300.00	240.00	1	....
Indian wars	49	1,323.27	1,268.33	67	118,984
Deceased veterans	49	1,323.27	1,268.33	67	58,536
Service connected	1	2,676.00	2,868.00	3	....
Non-service connected	48	1,296.22	1,236.00	64	....
Spanish-American War	15,154	1,247.47	1,323.32	20,153	5,240,060
Living veterans	209	2,776.34	2,739.96	847	3,371,993
Service connected	3	7,948.00	4,272.00	17	....
Non-service connected	206	2,723.39	2,717.66	830	....
Deceased veterans	14,946	1,220.52	1,303.51	19,306	1,868,067
Service connected	151	3,695.78	4,017.48	603	....
Non-service connected	14,786	1,197.16	1,276.38	18,701	....
Special acts	9	210.00	218.00	2	....
Mexican border service	783	1,063.33	1,228.27	1,084	8,630
Living veterans	220	1,917.00	2,046.60	541	5,273
Service connected	5	3,088.40	1,200.00	45	647
Non-service connected	215	1,894.19	2,066.36	496	4,605
Deceased veterans	563	[illegible]	904.54	543	3,523
Service connected	3	3,596.00	3,880.00	15	76
Non-service connected	560	880.79	888.71	528	3,447
World War I	755,296	1,348.49	1,543.80	1,228,107	44,099,714
Living veterans	230,843	2,081.37	2,395.45	588,890	30,517,909
Service connected	34,217	2,838.06	3,126.37	109,546	10,057,092
Retired emergency officers	202	5,633.20	6,318.48	1,241	187,522
Non-service connected	196,423	1,942.20	2,284.10	478,104	20,272,396
Special acts	1	120.00	120.00	....	....
Deceased veterans	524,455	864.51	1,168.86	639,217	13,581,806
Service connected	31,284	3,581.08	3,887.04	121,220	3,326,497
Non-service connected	493,171	829.24	996.12	517,997	10,255,809
World War II	2,607,473	1,905.06	2,054.27	5,477,019	77,295,001
Living veterans	1,899,015	1,939.02	2,199.15	4,271,714	59,103,698
Service connected	1,217,522	2,103.89	2,301.38	2,830,936	47,172,901
Non-service connected	681,493	1,640.20	2,013.73	1,440,778	11,930,807
Deceased veterans	708,458	1,464.53	1,680.58	1,205,305	18,181,382
Service connected	176,742	2,811.12	3,087.96	522,238	10,391,880
Non-service connected	531,716	1,039.65	1,196.70	683,067	7,789,532
Korean conflict	455,710	2,121.72	2,387.19	1,120,877	12,002,858
Living veterans	317,380	2,337.66	2,640.82	853,469	8,965,849
Service connected	237,102	2,511.63	2,743.06	660,947	7,816,886
Non-service connected	80,288	1,804.62	2,337.73	192,521	1,148,963
Deceased veterans	138,350	1,663.70	1,805.17	267,409	3,037,009
Service connected	38,237	2,942.85	3,199.34	127,229	1,747,744
Non-service connected	99,113	1,206.99	1,253.64	140,180	1,289,265
Regular establishment	289,406	2,604.10	2,858.62	829,814	8,536,275
Living veterans	240,210	2,449.52	2,633.71	631,893	6,061,214
Service connected	240,186	2,448.74	2,633.97	631,880	....
Retired reserve officers	1	7,200.00	8,004.00	7	326,729
Special acts	23	234.00	228.52	6	....
Deceased veterans	49,196	3,643.13	3,956.76	197,921	2,484,061
Service connected	49,188	3,643.69	3,957.36	197,919	....
Special acts	8	292.00	253.50	2	....
Vietnam era	645,385	2,311.93	2,533.52	1,646,779	9,694,249
Living veterans	552,418	2,227.15	2,451.54	1,358,215	7,860,649
Service connected	537,208	2,238.34	2,451.82	1,320,729	7,693,758
Non-service connected	15,210	1,893.52	2,441.95	37,486	156,891
Deceased veterans	92,967	2,800.66	3,020.67	288,564	1,833,601
Service connected	64,076	3,536.53	3,787.69	247,253	1,636,222
Non-service connected	28,891	1,252.26	1,319.56	41,311	197,379

Disability, Age Group, Period of Service —Sept. 1979

Age Group	Grand Total: Total³	Grand Total: Service-Connected	Grand Total: Non-Service-Connected	World War I: Total	World War I: Service-Connected	World War I: Non-Service-Connected	World War II: Total	World War II: Service-Connected	World War II: Non-Service-Connected
Average age	56.0	52.6	65.2	84.5	84.0	84.6	61.3	60.4	63.1
Total veterans	3,240,759	2,266,243	973,813	230,640	34,217	196,423	1,899,015	1,217,522	681,493
Under 20	....	....	....	....	....	....	....	....	....
20 to 24	26,113	25,817	296	....	....	....	....	....	....
25 to 29	99,137	96,378	2,759	....	....	....	....	....	....
30 to 34	237,019	229,907	7,112	....	....	....	....	....	....
35 to 39	103,576	99,551	4,025	....	....	....	....	....	....
40 to 44	106,660	98,960	7,700	....	....	....	....	....	....
45 to 49	230,758	186,618	44,140	....	....	....	....	....	....
50 to 54	383,732	281,533	102,199	....	....	....	226,488	150,017	76,471
55 to 59	699,677	529,091	170,586	....	....	....	636,870	468,437	168,433
60 to 64	547,162	386,270	160,892	....	....	....	503,840	343,796	160,044
Under 65	2,443,030	1,943,314	499,716	....	....	....	1,367,198	962,250	404,948
65 to 69	303,342	163,018	140,324	....	....	....	304,886	165,045	139,841
70 to 74	178,112	82,384	95,728	....	....	....	169,470	73,617	95,853
75 to 79	55,007	17,411	37,596	6,929	1,215	5,714	43,422	11,580	31,842
80 to 84	134,837	26,532	108,305	119,265	20,021	99,244	13,022	4,073	8,949
85 to 89	90,873	12,413	78,354	89,254	11,300	77,954	866	462	404
90 to 94	15,003	1,818	13,158	14,688	1,584	13,104	168	129	39
95 and over	853	218	635	504	97	407	105	77	28
65 and over	797,227	322,601	474,103	230,640	34,217	196,423	531,817	255,272	276,545

Age Group	Korean Conflict: Total	Korean Conflict: Service-Connected	Korean Conflict: Non-Service-Connected	Vietnam Era: Total	Vietnam Era: Service-Connected	Vietnam Era: Non-Service-Connected	Regular Estab-lishment	Spanish-American War¹	Mexican Border Service¹	R.E.O. and R.R.O.²
Average age	50.6	51.2	48.8	36.7	36.8	33.0	40.6	100.1	84.8	66.1
Total veterans	317,348	237,082	80,266	552,418	537,208	15,210	240,137	209	220	253
Under 20	....	....	....	....	....	....	....	....	....	....
20 to 24	....	....	....	10,030	9,734	296	16,083	....	....	....
25 to 29	....	....	....	87,816	85,057	2,759	11,321	....	....	....
30 to 34	....	....	....	232,099	224,987	7,112	4,920	....	....	....
35 to 39	....	....	....	70,765	66,740	4,025	32,811	....	....	....
40 to 44	14,210	7,311	6,899	33,167	32,357	810	59,301	....	....	....
45 to 49	156,963	112,962	44,001	45,724	45,585	139	37,351	....	....	....
50 to 54	98,025	72,338	25,687	33,291	33,250	41	25,928	....	....	....
55 to 59	22,659	20,525	2,134	22,425	22,406	19	17,723	....	....	....
60 to 64	13,909	13,065	844	12,830	12,826	4	16,763	....	....	....
Under 65	305,766	226,201	79,565	548,147	532,942	15,205	222,101	....	....	....
65 to 69	6,633	6,153	480	3,485	3,482	3	8,330	....	....	....
70 to 74	3,143	2,969	174	661	660	1	4,836	....	....	....
75 to 79	1,162	1,127	35	125	124	1	3,366	....	4	....
80 to 84	466	457	9	....	....	....	1,110	....	103	73
85 to 89	172	170	2	....	....	....	251	....	94	144
90 to 94	6	5	1	....	....	....	101	11	16	36
95 and Over	2	3	....	....	....	....	42	198	3	....
65 and over	11,582	10,881	701	4,271	4,266	5	18,036	209	220	253

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[1] *Service connected and non-service connected are combined in S.A.W. and Mexican Border service.*

[2] *Emergency, provisional, probationary, temporary or reserve officers in receipt of retired pay under Public Law 2-73, 743, 262-77 or 351-11.*

[3] *R.E.O. and R.R.O. included in Grand Total total, but not in Grand Total service-connected and non-service-connected.*

TABLE 59

Terminations of Awards, Disability, Death—Fiscal Year 1979

Reason for Termination	Total	World War I		World War II		Korean Conflict		Vietnam Era		Regular Establishment	Old² Wars	Mexican Border Service
		Service-Connected	Non-Service-Connected	Service-Connected	Non-Service-Connected	Service-Connected	Non-Service-Connected	Service-Connected	Non-Service-Connected			
Disability, total	303,742	4,460	46,201	26,895	99,426	3,451	6,860	10,830	2,620	9,422	110	62
Death of veteran	120,491	4,417	31,281	26,036	45,476	3,880	3,054	2,820	429	3,257	103	40
Disability less than 10 percent	2,194	....	....	99	....	90	....	1,566	....	507	.....	......
Disability less than permanent and total	704	....	26	....	444	....	105	....	129	......	.....	......
Estate in excess of $1,500	146	3	13	37	30	10	11	24	6	12	.....	......
Excessive corpus of estate	2,076	....	1,421	....	621	....	23	....	6	......	.....	4
Failure to cooperate	3,482	1	967	14	1,541	7	236	690	108	101	.....	......
Income provision	43,008	....	10,030	....	28,466	....	3,244	....	1,257	......	.....	11
Person entitled is incompetent	130	....	....	....	87	....	31	1	11	......	.....	......
Veteran on active duty or in receipt of retirement pay	1,269	....	3	47	21	46	2	678	1	434	.....	......
Failure to return questionnaire	13,251	....	3,310	....	6,302	....	1,190	....	458	......	7	6
Miscellaneous¹	20,080	35	2,860	670	3,433	274	486	2,179	218	5,108	.....	1
Death, total	210,199	1,821	61,130	12,865	150,284	3,280	53,535	8,691	8,280	5,849	2,190	87
Dependency not established or discontinued	132,442	14	798	1,557	96,337	888	26,347	3,011	1,741	2,414	5	......
Payee incompetent	65	1	3	1	46	....	13	....	....	1	.....	......
Death of payee	51,057	1,695	27,385	8,130	7,856	1,446	318	780	45	1,384	1,730	32
Income provisions	61,435	3	13,768	237	33,862	94	8,347	757	3,831	251	9	29
Excess corpus of estate	2,346	....	1,715	19	512	3	78	13	....	2	2	3
Person entitled (widow, child, parent) married	11,573	28	945	940	3,833	201	1,726	1,080	720	443	13	2
Failure to return questionnaire	33,839	7	11,467	212	10,536	67	4,526	301	949	164	101	10
Miscellaneous¹	23,836	62	4,827	1,181	9,063	601	2,865	2,361	996	1,220	321	3

¹Includes temporary terminations.

²Civil War, Indian Wars, Spanish American War

COMPENSATION AND PENSION **TABLE 60**

Veterans Receiving Compensation or Pension Compared With Estimated Veteran Population by Period of Service

Period of Service	Estimated Veterans Population	Number Receiving Compensation, Pension or Retirement	Percent Receiving Compensation, Pension or Retirement	Receiving Compensation Only	Percent Receiving Compensation	Receiving Pension and/or Retirement	Percent Receiving Pension
Total	30,072,000	3,240,283	10.78	2,266,267	7.54	974,016	3.24
World War I	594,000	230,843	38.86	34,217	5.76	196,626	33.10
World War II	12,674,000	1,899,015	14.98	1,217,522	9.61	681,493	5.37
Korean Conflict	4,679,000	317,388	6.78	237,102	5.07	80,286	1.71
Vietnam Era	8,363,000	552,418	6.61	537,208	6.42	15,210	.18
Peacetime	3,762,000	240,210	6.39	240,210	6.39	NA	......
Old Wars[2]	[1]	429	....	8	......	421	......

[1] *Less than 1000*
[2] *Includes Spanish American War and Mexican War*

COMPENSION AND PENSION **TABLE 61**

Veterans Receiving Compensation or Pension Compared With Estimated Veteran Population by Geographic Area of Residence—September 1979

U.S. Geographic Location	Estimated Veteran Population	Receiving Compensation or Pension	Percent Receiving Compensation or Pension
Total	30,072,000	3,240,283	10.78
East	7,984,000	865,948	10.85
South	6,336,000	826,683	13.05
Midwest	7,840,000	728,215	9.29
Southwest	2,699,000	339,140	12.57
West	5,214,000	480,298	9.21

Composition of Geographic Locations:

East – Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont.

South – Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Puerto Rico, South Carolina, Tennessee, Virginia, and West Virginia.

Midwest – Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

Southwest – Arizona, New Mexico, Oklahoma, Texas and Utah.

West – Alaska, California, Colorado, Hawaii, Idaho, Montana, Nevada, Oregon, Philippines, Washington and Wyoming.

Death Benefit (Compensation, Dependency & Indemnity Compensation or Pension) Cases on the Rolls Compared to the Number of Deceased Veterans Who Participated in each Period of Service

Period of Service	Deceased Participants	Total Death Benefit Cases	Percent on Rolls	Death Compensation and DIC Cases	Percent on Rolls	Death Pension Cases[1]	Percent of Total
Total	14,320,000	1,529,206	10.68	360,688	2.52	1,168,518	8.16
World War I	4,150,000	524,455	12.63	31,284	.75	493,171	11.88
World War II	3,861,000	708,458	18.35	176,742	4.58	531,716	13.77
Korean Conflict	2,129,000	138,350	6.50	39,237	1.84	99,113	4.66
Vietnam Era	1,471,000	92,967	6.32	64,076	4.36	28,891	1.96
Indian War	106,000	49	[3]	1	[3]	48	3
Mexican Border	[2]	563	.....	3	....	560	....
Civil War	2,213,000	223	.01	6	[3]	217	.01
Peacetime	[2]	49,196	.....	49,188	....	8	....
Spanish American War	391,000	14,945	3.82	151	.04	14,794	3.78

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[1] *Includes 19 Special Act Cases*

[2] *Data not available*

[3] *Less than 0.005 percent*

Disability: Class of Dependent, Period of Service—Sept. 1979

Class of Dependent	Total			World War I		World War II		Korean Conflict	
	Number	Monthly Value	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value
Total veterans	2,266,243	$459,103,976	$202.58	34,217	$290.53	1,217,522	$191.78	237,102	$228.63
Veterans less than 30 percent disabled (no dependency benefit)	1,260,713	69,528,773	55.15	15,443	76.97	673,315	57.48	126,526	58.22
Veterans 30 percent or more disabled	1,005,530	389,575,203	387.43	18,774	411.03	544,207	361.75	110,576	425.86
Without dependents	335,552	103,276,605	307.78	9,028	365.01	183,152	282.78	34,366	325.17
With dependents	669,978	286,298,598	427.33	9,746	453.75	361,055	401.81	76,210	471.23
Spouse only	383,853	160,245,051	417.46	9,580	452.54	274,738	397.97	33,105	482.18
Spouse, child or children	248,330	106,456,408	428.69	130	539.77	74,485	396.90	36,970	443.81
Spouse, child or children, and parent or parents	2,925	2,103,575	719.19	....	....	833	602.72	496	782.85
Spouse, parent, or parents	2,176	1,462,417	672.07	....	....	1,320	633.02	382	752.30
Child or children only	26,361	11,935,984	452.79	35	495.20	6,879	406.82	3,987	484.14
Child or children and parent or parents	565	436,974	773.41	....	....	108	665.00	83	836.31
Parent or parents only	5,864	4,580,188	781.05	1	849.00	2,482	750.63	1,175	806.89
Total dependents on whose account additional compensation was being paid	1,176,302	....	....	9,908	....	486,051	....	153,135	....
Spouses	637,088	....	....	9,710	....	351,486	....	70,965	....
Children	526,042	....	....	197	....	128,411	....	79,768	....
Parents	13,172	....	....	1	....	6,154	....	2,402	....

Class of Dependent	Vietnam Era		Regular Establishment		Spanish-American War		Mexican Border Service	
	Number	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value
Total veterans	537,208	$204.32	240,186	$219.50	3	$ 356.00	5	$100.00
Veterans less than 30 percent disabled (no dependency benefit)	306,234	55.35	139,210	54.82	1	44.00	3	44.00
Veterans 30 percent or more disabled	230,974	401.82	100,976	446.39	2	512.00	2	184.00
Without dependents	73,506	321.78	35,479	378.32	1	166.00	1	232.00
With dependents	157,468	439.19	65,497	484.34	1	858.00	1	136.00
Spouse only	40,899	419.13	25,329	492.18	1	858.00	1	136.00
Spouse, child or children	102,356	435.16	34,481	460.66	....	....	....	....
Spouse, child or children, and parent or parents	1,151	748.38	355	829.84	....	....	....	....
Spouse, parent or parents	315	689.17	148	770.77	....	....	....	....
Child or children only	11,127	463.56	4,233	489.22	....	....	....	....
Child or children and parent or parents	272	778.32	102	834.38	....	....	....	....
Parent or parents only	1,348	781.82	958	864.26	....	....	....	....
Total dependents on whose account additional compensation was being paid	381,076	....	147,130	....	1	....	1	....
Spouses	144,721	....	60,204	....	1	....	1	....
Children	232,530	....	85,136	....	....	....	....	....
Parents	3,825	....	1,790	....	....	....	....	....

TABLE 64

COMPENSATION

Death: Total, Class of Beneficiary, Period of Service—Sept. 1979

Class of Beneficiary	Total			World War I		World War II		Korean Conflict		Vietnam Era	
	Number	Monthly Value	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value
Total cases	360,678	102,483,987	284.16	31,284	321.42	176,742	257.33	39,227	286.53	64,076	315.64
Compensation	64,018	5,041,183	78.75	82	106.45	49,627	78.82	11,773	77.85	13	77.69
Dependency and indemnity compensation	293,057	95,987,890	327.54	31,201	321.88	124,500	325.40	26,679	345.52	64,050	315.67
Dependency and indemnity compensation and compensation	3,613	1,463,815	405.15	1	372.00	2,616	402.46	785	411.62	13	411.38
Surviving Spouse alone	182,741	65,443,815	358.11	30,341	321.08	86,810	344.82	18,389	389.50	17,388	388.78
Surviving Spouse and children	30,601	12,928,083	422.47	378	486.10	5,125	404.85	2,347	412.18	17,142	427.10
Surviving Spouse, children and mother	2,225	1,158,036	520.47	......	......	134	537.35	71	521.86	1,653	519.37
Surviving Spouse, children and father	280	142,893	510.33	......	......	17	564.65	8	606.25	215	508.93
Surviving Spouse, children, mother and father	639	345,023	539.94	......	......	7	578.71	12	535.75	514	537.20
Surviving Spouse and mother	7,524	3,427,583	455.56	4	471.25	4,003	460.40	1,007	448.63	1,310	466.01
Surviving Spouse and father	954	434,251	455.19	......	......	586	468.04	112	433.61	144	457.11
Surviving Spouse, mother and father	849	405,718	477.88	......	......	319	482.60	121	446.16	255	481.22
Children alone	19,214	3,619,687	188.39	517	237.85	2,096	207.24	1,082	182.27	12,212	183.85
Children and mother	1,707	497,424	291.40	......	......	91	332.40	69	293.29	1,301	290.72
Children and father	194	53,043	273.42	......	......	10	355.10	7	303.57	159	267.06
Children, mother and father	504	154,792	307.13	......	......	6	415.00	7	295.14	426	307.29
Mother alone	81,226	8,288,350	102.04	141	183.92	55,016	103.39	12,184	90.39	7,580	110.75
Father alone	9,888	1,081,112	109.34	3	141.00	6,883	118.46	1,409	87.17	865	87.87
Mother and father	12,142	1,513,908	124.68	......	......	5,639	130.83	2,283	98.83	2,954	136.52
Total dependents	464,808	....	......	31,734	......	195,712	......	47,406	......	114,426	......
Surviving Spouses	235,790	....	......	30,623	......	106,988	......	22,184	......	38,598	......
Children	85,940	....	......	958	......	10,030	......	6,487	......	54,320	......
Mothers	106,829	....	......	158	......	65,218	......	15,766	......	15,976	......
Fathers	25,460	....	......	3	......	13,467	......	3,958	......	5,532	......

Class of Beneficiary	Regular Establishment		Civil War		Indian Wars		Spanish-American War		Mexican Border Service	
	Number	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value
Total cases	49,188	329.78	6	320.17	1	239.00	151	334.79	3	321.67
Compensation	2,523	78.65	......	......	......	......	......	......	......	....
Dependency and indemnity compensation	46,486	343.05	6	320.17	1	239.00	151	334.79	3	321.67
Dependency and indemnity compensation and compensation	198	414.72	......	......	......	......	......	......	......	....
Surviving Spouse alone	29,673	381.09	3	401.33	......	......	137	338.42	3	321.67
Surviving Spouse and children	5,607	425.72	......	......	......	......	2	641.50	......	....
Surviving Spouse, children and mother	367	519.03	......	......	......	......	......	......	......	....
Surviving Spouse, children and father	40	490.00	......	......	......	......	......	......	......	....
Surviving Spouse, children, mother and father	106	551.16	......	......	......	......	......	......	......	....
Surviving Spouse and mother	1,200	457.06	......	......	......	......	......	......	......	....
Surviving Spouse and father	112	450.38	......	......	......	......	......	......	......	....
Surviving Spouse, mother and father	154	486.77	......	......	......	......	......	......	......	....
Children alone	3,291	183.90	3	239.00	1	239.00	12	242.25	......	....
Children and mother	246	279.31	......	......	......	......	......	......	......	....
Children and father	18	272.44	......	......	......	......	......	......	......	....
Children, mother and father	65	298.48	......	......	......	......	......	......	......	....
Mother alone	6,315	100.61	......	......	......	......	......	......	......	....
Father alone	728	91.37	......	......	......	......	......	......	......	....
Mother and father	1,266	117.27	......	......	......	......	......	......	......	....
Total dependents	64,564	......	6	......	1	......	157	......	3	....
Surviving Spouses	37,252	......	3	......	......	......	139	......	3	....
Children	15,104	......	3	......	1	......	18	......	......	....
Mothers	9,710	......	......	......	......	......	......	......	......	....
Fathers	2,480	......	......	......	......	......	......	......	......	....

TABLE 65

Disability, Degree of Impairment, Type of Major Disability, Period of Service—Sept. 1979

Degree of Impairment	Total				Tuberculosis (Lungs and Pleura)				Psychiatric and Neurological Diseases				General Medical and Surgical Conditions			
	Number	Percent of Total	Monthly Value	Average Monthly Value	Number	Percent of Total Tuberculosis	Percent of Degree of Impairment	Average Monthly Value	Number	Percent of Total Psychiatric and Neurological Diseases	Percent of degree of impairment	Average Monthly Value	Number	Percent of Total General Medical and Surgical Conditions	Percent of Degree of Impairment	Average Monthly Value
TOTAL																
Total	2,266,243	100.0	459,103,886	202.58	50,427	100.0	2.2	168.68	471,226	100.0	20.8	353.38	1,744,590	100.0	77.0	162.94
No disability	27,390	1.2	1,822,667	66.54	25,657	51.0	93.7	67.04	......	......	......	......	1,733	.1	6.3	59.27
10 percent	878,620	38.8	39,057,896	44.45	1,486	2.9	.2	57.69	133,498	28.2	15.2	44.26	743,636	42.6	84.6	44.46
20 percent	354,645	15.6	28,645,401	80.77	4,056	8.0	1.1	96.05	24,998	5.3	7.0	81.13	325,591	18.7	91.8	71.32
30 percent	316,900	14.0	42,849,564	135.21	10,145	20.1	3.2	134.28	77,947	16.5	24.6	132.78	228,808	13.1	72.2	136.09
40 percent	184,862	8.2	34,844,476	188.49	1,188	2.4	.6	185.87	26,266	5.6	14.2	186.61	157,408	9.0	85.2	188.89
50 percent	114,721	5.1	30,602,200	266.75	1,332	2.6	1.2	274.40	43,300	9.2	37.7	261.53	70,089	4.0	61.1	268.83
60 percent	124,044	5.5	64,532,763	520.24	1,343	2.7	1.1	487.21	19,716	4.2	15.9	442.71	102,985	5.9	83.0	535.61
70 percent	89,236	3.9	59,026,245	661.46	1,000	2.0	1.1	468.70	46,893	10.0	52.6	707.29	41,343	2.4	46.3	614.15
80 percent	40,786	1.8	27,857,396	683.01	1,672	3.3	4.1	548.59	11,602	2.5	28.4	710.53	27,512	1.6	67.5	679.58
90 percent	13,945	.6	10,360,566	742.96	120	.2	.9	690.06	3,809	.8	27.3	763.14	10,016	.6	71.8	736.92
100 percent	121,094	5.3	119,504,813	986.88	2,429	4.8	2.0	877.03	83,226	17.7	68.7	949.02	35,439	2.0	29.3	1,086.80
WORLD WAR I																
Total	34,217	100.0	8,914,572	260.53	4,902	100.0	14.3	198.72	6,491	100.0	19.0	400.35	22,824	100.0	66.7	234.13
No disability	465	1.4	29,330	63.06	269	5.5	57.9	67.61	......	......	......	......	196	.8	42.1	56.96
10 percent	6,484	18.9	340,308	52.48	15	.3	.2	63.27	447	6.9	6.9	54.77	6,022	26.4	92.9	52.29
20 percent	8,469	24.7	816,344	96.39	3,449	70.4	40.7	101.13	1,012	15.6	12.0	102.62	4,008	17.6	47.3	90.76
30 percent	4,775	14.0	653,016	136.76	341	7.0	7.1	143.66	858	13.2	18.0	139.41	3,576	15.7	74.9	135.46
40 percent	3,034	8.9	570,041	187.88	152	3.1	5.0	193.14	539	8.3	17.8	182.91	2,343	10.3	77.2	186.39
50 percent	2,454	7.2	645,163	262.90	42	.9	1.7	275.14	868	13.4	35.4	264.51	1,544	6.8	62.9	261.67
60 percent	2,718	7.9	1,391,074	511.80	53	1.1	1.9	581.02	399	6.2	14.7	376.74	2,266	9.9	83.4	534.14
70 percent	1,305	3.8	749,271	574.15	11	.2	.8	511.18	470	7.2	36.0	580.61	824	3.6	63.2	571.31
80 percent	844	2.5	520,092	616.22	11	.2	1.3	608.45	211	3.2	25.0	565.41	622	2.7	73.7	632.54
90 percent	213	.6	146,340	687.04	7	.1	3.3	597.14	22	.3	10.3	690.36	184	.8	86.4	691.26
100 percent	3,456	10.1	3,053,592	883.56	552	11.2	16.0	848.46	1,665	25.7	48.2	876.92	1,239	5.4	35.8	909.73
WORLD WAR II																
Total	1,217,522	100.0	233,496,106	191.78	28,135	100.0	2.3	178.85	277,154	100.0	22.8	305.04	912,233	100.0	74.9	187.82
No disability	15,721	1.3	1,048,210	66.68	15,000	53.3	95.4	67.01	......	......	......	......	721	.1	4.6	59.69
10 percent	478,074	39.3	21,172,319	44.29	662	2.3	.2	62.76	90,974	32.8	19.0	44.13	386,438	42.4	80.8	44.29
20 percent	179,491	14.7	14,411,188	80.29	368	1.3	.2	80.54	14,484	5.2	8.1	80.19	164,639	18.0	91.7	80.30
30 percent	179,511	14.7	23,814,403	132.66	5,989	21.3	3.3	133.31	50,056	18.1	27.9	131.07	123,466	13.5	68.8	133.28
40 percent	102,046	8.4	18,826,407	184.49	632	2.2	.6	184.72	15,948	5.7	15.6	182.06	85,466	9.4	83.8	184.94
50 percent	64,418	5.3	16,926,399	262.76	909	3.2	1.4	276.16	24,070	8.7	37.4	258.56	39,439	4.3	61.2	266.02
60 percent	69,073	5.7	35,792,722	518.19	947	3.4	1.4	483.93	11,054	4.0	16.0	425.94	57,072	6.3	82.6	536.62
70 percent	47,398	3.9	31,407,986	662.64	844	3.0	1.8	461.66	25,179	9.1	53.1	723.43	21,375	2.3	45.1	598.97
80 percent	22,179	1.8	14,626,731	659.49	1,508	5.4	6.8	543.95	6,119	2.2	27.6	696.71	14,552	1.6	65.6	655.80
90 percent	6,844	.6	4,934,392	720.98	103	.4	1.5	669.19	1,658	.6	24.2	728.81	5,083	.6	74.3	719.07
100 percent	52,768	4.3	50,537,348	957.73	1,173	4.2	2.2	896.31	37,612	13.6	71.3	936.09	13,983	1.5	26.5	1,018.86

KOREAN CONFLICT																
Total	237,102	100.0	54,308,479	229.05	10,278	100.0	4.3	111.76	43,794	100.0	18.5	470.28	183,030	100.0	77.2	177.40
No disability	7,256	3.1	483,999	66.70	6,972	67.9	96.1	66.96	......	.....	.....	......	284	.2	3.9	59.89
10 percent	82,818	34.9	3,696,203	44.63	250	2.4	.3	65.29	9,164	20.9	11.1	44.69	73,404	40.1	88.6	44.57
20 percent	36,447	15.4	2,933,423	80.48	80	.8	.2	80.00	1,888	4.3	5.2	80.43	34,479	18.8	94.6	80.48
30 percent	31,877	13.4	4,377,011	137.31	2,061	20.1	6.5	134.76	5,942	13.6	18.6	135.72	23,874	13.0	74.9	137.93
40 percent	19,829	8.4	3,807,209	192.00	216	2.1	1.1	183.90	2,285	5.2	11.5	190.56	17,328	9.5	87.4	192.29
50 percent	11,606	4.9	3,178,418	273.86	249	2.4	2.1	270.02	3,616	8.3	31.2	270.56	7,741	4.2	66.7	275.53
60 percent	14,329	6.0	7,645,240	533.55	179	1.7	1.2	468.31	2,220	5.0	15.5	486.65	11,930	6.5	83.3	547.31
70 percent	10,473	4.4	7,139,429	681.70	76	.7	.7	499.74	4,991	11.4	47.7	728.46	5,406	2.9	51.6	641.06
80 percent	4,850	2.1	3,457,405	712.87	64	.6	1.3	626.56	1,394	3.2	28.7	743.45	3,392	1.9	70.0	701.93
90 percent	1,670	.7	1,247,317	746.90	7	.1	.4	618.86	479	1.1	28.7	766.57	1,184	.7	70.9	738.61
100 percent	15,947	6.7	16,242,825	1,018.55	124	1.2	.8	873.45	11,816	27.0	74.1	903.79	4,008	2.2	25.1	1,097.39
VIETNAM ERA																
Total	537,208	100.0	109,761,408	204.32	2,055	100.0	.4	220.00	96,183	100.0	17.9	391.22	438,970	100.0	81.7	163.34
No disability	681	.1	44,563	65.44	439	21.4	64.5	66.84	......	.....	.....	......	242	.1	35.5	59.27
10 percent	213,233	39.7	9,477,817	44.45	409	19.9	.2	44.73	22,058	22.9	10.3	44.34	190,766	43.5	89.5	44.46
20 percent	92,309	17.2	7,426,891	80.46	56	2.7	.1	80.00	5,602	5.8	6.1	80.18	86,651	19.7	93.9	80.48
30 percent	69,021	12.8	9,586,354	138.89	644	31.3	.9	135.47	13,971	14.5	20.2	136.11	54,406	12.4	78.9	139.65
40 percent	43,945	8.2	8,515,836	193.78	103	5.0	.2	187.03	5,520	5.8	12.6	191.40	38,322	8.7	87.2	194.15
50 percent	26,733	5.0	7,290,864	272.73	53	2.6	.2	267.32	10,059	10.5	37.6	264.85	16,621	3.8	62.2	277.52
60 percent	25,487	4.7	12,492,704	490.16	51	2.5	.2	489.02	4,480	4.6	17.6	454.81	20,976	4.8	82.3	497.08
70 percent	21,776	4.1	14,036,425	644.58	21	1.0	.1	602.76	11,250	11.7	51.7	608.76	10,506	2.4	48.2	618.77
80 percent	9,716	1.8	6,898,324	710.00	12	.6	.1	732.25	2,921	3.0	30.1	721.67	6,783	1.5	69.8	704.93
90 percent	4,234	.8	3,261,048	770.21	1	.1	.1	525.00	1,352	1.4	31.9	797.93	2,881	.7	68.0	757.20
100 percent	30,073	5.6	30,730,582	1,021.87	266	12.9	.9	870.36	18,990	19.8	63.1	938.46	10,817	2.4	36.0	1,172.11
REGULAR ESTABLISHMENT																
Total	240,186	100.0	52,719,853	219.50	5,056	100.0	2.1	157.96	47,601	100.0	19.8	444.29	187,529	100.0	78.1	164.16
No disability	3,267	1.4	216,666	66.32	2,977	58.9	91.1	67.01	......	.....	.....	......	290	.2	8.9	59.21
10 percent	98,007	40.8	4,371,072	44.60	149	2.9	.2	57.50	10,825	22.8	11.0	44.52	87,033	46.4	88.8	44.59
20 percent	37,929	15.8	3,057,565	80.61	102	2.0	.3	80.90	2,013	4.2	5.3	80.33	35,814	19.1	94.4	80.63
30 percent	31,715	13.2	4,418,644	139.32	1,110	22.0	3.5	135.08	7,119	15.0	22.5	134.96	23,486	12.5	74.0	140.85
40 percent	16,008	6.7	3,124,916	195.21	86	1.7	.5	184.98	1,973	4.1	12.3	190.40	13,950	7.4	87.2	195.95
50 percent	9,509	4.0	2,561,124	269.34	79	1.6	.8	272.23	4,686	9.9	49.3	262.24	4,744	2.5	49.9	276.30
60 percent	12,437	5.2	7,211,023	579.80	113	2.2	.9	515.67	1,583	3.3	12.7	510.30	10,741	5.7	86.4	590.71
70 percent	8,284	3.4	5,693,134	687.24	48	.9	.6	475.02	5,003	10.5	60.4	703.46	3,233	1.7	39.0	665.30
80 percent	3,197	1.3	2,354,844	736.58	77	1.5	2.4	528.90	957	2.0	29.9	746.95	2,163	1.2	67.7	738.50
90 percent	984	.4	771,469	784.01	2	.1	.2	691.50	298	.6	30.3	796.90	684	.4	69.6	778.67
100 percent	18,849	7.8	18,939,416	1,004.80	314	6.2	1.7	866.05	13,144	27.6	69.7	963.03	5,391	2.9	28.6	1,116.84
SPANISH AMERICAN WAR																
Total	3	100.0	1,068	356.00	1	100.0	33.3	44.00	1	100.0	33.3	166.00	1	100.0	33.3	858.00
No disability	......	.....	....	......	......	.....	.....	......	......	.....	.....	......	....	.....	.....	......
10 percent	1	33.3	44	44.00	1	100.0	100.0	44.00	......	.....	.....	......	....	.....	.....	......
20 percent	......	.....	....	......	......	.....	.....	......	......	.....	.....	......	....	.....	.....	......
30 percent	......	.....	....	......	......	.....	.....	......	......	.....	.....	......	....	.....	.....	......
40 percent	1	33.3	166	166.00	......	.....	.....	......	1	100.0	100.0	166.00	....	.....	.....	......
50 percent	......	.....	....	......	......	.....	.....	......	......	.....	.....	......	....	.....	.....	......
60 percent	......	.....	....	......	......	.....	.....	......	......	.....	.....	......	....	.....	.....	......
70 percent	......	.....	....	......	......	.....	.....	......	......	.....	.....	......	....	.....	.....	......

Disability, Degree of Impairment, Type of Major Disability, Period of Service—Sept. 1979—Continued

Degree of Impairment	Total				Tuberculosis (Lungs and Pleura)				Psychiatric and Neurological Diseases				General Medical and Surgical Conditions			
	Number	Percent of Total	Monthly Value	Average Monthly Value	Number	Percent of Total Tuberculosis	Percent of Degree of Impairment	Average Monthly Value	Number	Percent of Total Psychiatric and Neurological Diseases	Percent of Degree of Impairment	Average Monthly Value	Number	Percent of Total General Medical and Surgical Conditions	Percent of Degree of Impairment	Average Monthly Value
80 percent	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......
90 percent	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......
100 percent	1	33.3	[illegible]	[illegible]	......	......	......	......	......	......	......	......	1	100.0	100.0	[illegible]
MEXICAN BORDER SERVICE																
Total	5	100.0	500	100.00	......	......	......	......	2	100.0	40.0	184.00	3	100.0	60.0	44.00
No disability	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......
10 percent	3	60.0	132	44.00	......	......	......	......	......	......	......	......	3	100.0	100.0	44.00
20 percent	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......
30 percent	1	20.0	136	136.00	......	......	......	......	1	50.0	100.0	136.00	......	......	......	......
40 percent	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......
50 percent	1	20.0	232	232.00	......	......	......	......	1	50.0	100.0	232.00	......	......	......	......
60 percent	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......
70 percent	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......
80 percent	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......
90 percent	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......
100 percent	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......	......

TABLE 66

PENSION

Disability: Total, Period of Service, Type of Major Disability—Sept. 1979

Type of Pension and Disability	Total				World War I			World War II		
	Number	Percent of Total	Monthly Value	Average Monthly Value	Number	Percent of Total	Average Monthly Value	Number	Percent of Total	Average Monthly Value
Total	973,913	100.0	170,237,037	174.81	196,423	100.0	175.67	681,493	100.0	167.81
Tuberculosis (lungs and pleura)	12,034	1.2	2,405,939	199.93	1,485	0.8	233.37	8,151	1.2	191.80
Psychiatric and neurological diseases	214,943	22.1	45,435,859	211.39	22,781	11.6	293.14	150,296	22.1	253.17
Psychoses	54,090	5.6	10,433,897	186.02	2,114	1.1	292.45	34,839	5.1	184.90
Other psychiatric and neurological diseases	160,853	16.5	35,001,962	220.34	20,667	10.5	293.21	115,457	17.0	258.70
General medical and surgical conditions	630,234	64.7	108,366,386	171.92	157,595	80.2	177.12	420,857	61.7	167.83
No disability shown	116,603	12.0	14,029,884	120.42	14,562	7.4	153.07	101,289	14.9	119.90
Old law	44,847	4.6	3,893,098	84.80	38,410	19.6	84.29	5,604	0.8	67.90
Sec. 306	782,170	80.3	119,720,348	153.06	136,360	69.4	182.54	570,393	83.7	143.25
P.L. 95-588	146,787	15.1	46,713,021	318.24	21,654	11.0	349.51	105,496	15.5	304.80

Type of Pension and Disability	Korean Conflict			Vietnam Era			Spanish-American War			Mexican Border Service		
	Number	Percent of Total	Average Monthly Value	Number	Percent of Total	Average Monthly Value	Number	Percent of Total	Average Monthly Value	Number	Percent of Total	Average Monthly Value
Total	80,286	100.0	194.81	15,210	100.0	203.48	206	100.0	229.33	215	100.0	172.45
Tuberculosis (lungs and pleura)	1,336	1.7	217.25	82	0.5	226.79	....	....	....	....	....	....
Psychiatric and neurological diseases	32,218	40.1	196.86	9,484	62.4	194.07	43	20.9	293.02	20	9.3	309.95
Psychoses	13,351	16.6	174.55	5,684	37.4	182.13	....	....	....	2	0.9	284.50
Other psychiatric and neurological diseases	18,867	23.5	212.65	3,800	25.0	211.94	43	20.9	293.02	18	8.4	312.33
General medical and surgical conditions	46,388	57.8	193.76	5,633	37.0	219.92	51	24.7	287.10	30	14.0	284.57
No disability shown	344	0.4	128.17	11	0.1	294.38	112	54.4	183.29	165	76.7	139.65
Old law	698	0.9	85.91	....	....	....	126	61.2	113.60	....	....	....
Sec. 306	63,193	78.7	154.11	11,982	78.8	163.17	69	33.5	378.75	192	89.3	156.93
P.L. 95-588	16,375	20.4	356.51	3,228	21.2	353.01	11	5.3	563.10	23	10.7	302.80

TABLE 67

PENSION

Death: Total, Class of Beneficiary, Period of Service—Sept. 1979

Class of Beneficiary	Total			World War I		World War II		Korean Conflict	
	Number	Monthly Value	Average Monthly	Number	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value
Total cases	1,168,490	109,220,780	93.47	493,171	83.18	531,715	99.73	99,113	104.47
Surviving spouse alone	837,343	76,236,049	91.05	474,731	82.97	331,763	101.01	14,882	123.48
Surviving spouse and children	109,716	16,383,185	149.32	8,071	144.96	70,143	147.32	21,562	160.01
Children alone	221,430	16,601,546	74.97	10,369	62.90	129,810	71.96	62,889	81.27
Total dependents	1,472,329	....	....	503,169	....	695,336	....	192,632	....
Surviving spouses	947,054	....	....	482,799	....	401,905	....	36,223	....
Children	525,275	....	....	20,369	....	293,461	....	156,409	....

Class of Beneficiary	Vietnam Era		Civil War		Indian Wars		Spanish-American War		Mexican Border Service	
	Number	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value	Number	Average Monthly Value
Total cases	28,891	109.96	214	95.37	48	102.92	14,786	106.37	560	74.06
Surviving spouse alone	1,769	124.80	87	127.05	38	110.82	13,747	108.18	546	73.40
Surviving spouse and children	9,809	162.85	....	....	....	....	124	189.53	9	139.80
Children alone	17,313	84.44	127	73.10	10	73.10	915	73.26	5	61.00
Total dependents	65,365	....	215	....	48	....	14,964	....	571	....
Surviving spouses	11,576	....	87	....	38	....	13,871	....	555	....
Children	53,789	....	129	....	10	....	1,093	....	16	....

Persons in Training During Fiscal Year by Program and Period of Service

Program	Fiscal Year				
	1979	1978	1977	Transition Quarter	1976
Post-Korean Educational Assistance Program					
In training during year – Total	1,278,538	1,521,840	1,937,874	1,320,947	2,821,514
Institutions of higher learning	967,790	1,144,075	1,380,025	889,207	1,923,639
Resident schools other than college	175,098	211,241	313,646	183,596	449,700
Correspondence schools	51,383	72,945	131,811	176,568	302,134
On-job training	84,267	93,579	112,392	72,576	146,041
Children's Educational Assistance Program					
In training during year – Total	85,696	88,299	88,158	52,190	80,689
Institutions of higher learning	77,915	80,402	80,257	48,208	72,996
Schools other than college	7,180	7,291	7,363	3,769	7,208
Special restorative training	73	94	82	37	76
On-job training	528	512	456	176	409
Period of service of beneficiary's parent					
World War I	1,108	1,090	1,225	795	1,256
World War II	28,899	31,756	33,220	19,715	32,190
Korean conflict	13,519	13,848	13,676	7,969	12,484
Vietnam era	31,225	29,507	27,437	16,008	22,450
Other	10,945	12,098	12,582	7,703	12,300
Educational Assistance for Spouses of Totally Disabled or Deceased Veterans					
In training during year – Total	17,260	19,394	19,470	11,740	19,092
Institutions of higher learning	13,977	15,548	15,461	9,481	14,545
Schools other than college	3,239	3,801	3,964	2,227	4,486
Special restorative training	2	2	6	4	8
On-job training	42	43	39	28	53
Period of service of beneficiary's spouse					
World War I	183	205	227	164	297
World War II	3,553	4,300	4,295	2,605	4,328
Korean conflict	1,854	2,250	2,314	1,440	2,362
Vietnam era	9,758	10,184	9,986	5,816	9,253
Other	1,912	2,455	2,649	1,715	2,852
Vocational Rehabilitation Program for Disabled Veterans					
In training during year – Total	29,470	31,018	33,231	19,914	29,448[1]
Institutions of higher learning	21,672	23,145	24,728	14,716	20,983
Schools other than college	6,195	6,233	6,703	3,886	5,994
On-job training	1,116	1,160	1,038	645	1,038
Institutional on-farm	149	173	199	130	191
Unknown	338	307	563	540[2]	1,233[2]
Period of service of veterans					
World War II	385	353	90	19	95
Korean conflict	440	454	308	163	300
Vietnam era	26,870	28,809	31,601	19,013	27,536
Post-Korean and between wars	1,785	1,400	1,232	719	1,518

[1] *Estimated.*

[2] *The unknown count of type of training was generated by a change from a punched card to magnetic tape system. Steps are being taken to correct these items.*

TABLE 69

HOUSING ASSISTANCE

Guaranteed or Insured Loans, Direct Loans, Property Management

Item	Cumulative Through Sept. 30, 1979	Fiscal Year 1979	Fiscal Year 1978
Guaranteed or Insured Loans			
Number of loans, total			
Home	10,343,900	364,578	380,869
Mobile home	10,310,216	357,850	376,561
	33,684	6,728	4,308
Amount of loans ($000), total			
Home	$170,061,276	$16,071,991	$14,658,657
Mobile home	$169,665,355	$15,955,333	$14,598,972
	$ 395,921	$ 116,658	$ 59,685
Amount of guaranty and insurance ($000), total			
Home	$ 83,369,861	$ 7,342,507	$ 6,115,563
Mobile Home	$ 83,208,855	$ 7,284,387	$ 6,085,824
	$ 161,006	$ 58,120	$ 29,739
Defaults and claims:			
Defaults reported			
Loans in default-end of period	2,845,070	120,284	117,204
Defaults disposed of, total	....	48,141	49,448
Cured or withdrawn	2,796,929	121,591	116,099
Percent	2,397,303	108,268	101,487
Claims vouchered for payment	85.7	89.0	87.4
Rate per 1000 loans outstanding	399,626	13,323	14,612
Average number of loans outstanding	....	3.33	3.66
	....	4,004,578	3,988,172
Direct Loans			
Number of loans fully disbursed			
Amount of loans fully disbursed ($000)	331,837	1,419	1,830
	$ 3,401,417	$ 37,318	$ 46,822
Property Management			
Number acquired			
Number sold	434,287	13,139	15,578
Number redeemed	419,674	14,722	15,753
Number on hand-end of period	5,163	281	250
	....	9,450	11,291

TABLE 70

INSURANCE

Appropriations and Other Receipts Versus Expenditures Cumulative Through September 30, 1979

Item	United States Government Life Insurance Fund	National Service Life Insurance Fund	Veterans Reopened Insurance Fund	Veterans Special Life Insurance Fund	Service-Disabled Veterans Insurance Fund	Servicemen's Group Life Insurance Fund
Appropriations and other receipts:						
Appropriations	$...........	$...........	$...........	$...........	$ 4,250,000	$...........
Receipts other than appropriations	4,636,503,481	35,574,902,439	689,071,737	1,202,311,853	352,154,975	1,856,086,074
Total	4,636,503,481	35,574,902,439	689,071,737	1,202,311,853	356,404,975	1,856,086,074
Expenditures:						
Fiscal Year	84,779,843	1,093,468,186	23,491,719	75,186,689	29,278,539	105,653,391
Cumulative to September 30	4,119,364,978	26,587,822,509	209,207,997	550,008,629	344,062,020	1,856,086,074
Covered into U.S. Treasury	....	....	....	4,250,000	....	....
Investments, loans and liens	518,873,965	9,183,244,671	481,071,137	691,453,798	32,104,536	....
Balance	−1,735,462	−2[illegible] 164,941	−1,207,397	− 43,400,574	−19,761,580	....

Summary of Operations (Accrual Basis)
(In thousands)

Item	U.S. Government Life Insurance: Fiscal Year 1979	U.S. Government Life Insurance: Cumulative Totals From Origin January 1919 to September 30, 1979	National Service Life Insurance: Fiscal Year 1979	National Service Life Insurance: Cumulative Totals From Origin October 1940 to September 30, 1979	Veterans Special Life Insurance: Fiscal Year 1979	Veterans Special Life Insurance: Cumulative Totals From Origin April 1951 to September 30, 1979	Service-Disabled Veterans Insurance: Fiscal Year 1979	Service-Disabled Veterans Insurance: Cumulative Totals From Origin April 1951 to September 30, 1979	Veterans Reopened Insurance: Fiscal Year 1979	Veterans Reopened Insurance: Cumulative Totals From Origin May 1965 to September 30, 1979
INCOME										
Premiums	$ 4,942	$2,073,758	$ 616,385	$10,741,609	$ 60,965	$ 640,351	$26,000	$ 288,092	$21,063	$452,461
Policy proceeds left to be paid in installments	3,372	777,607	32,003	5,354,061	1,585	37,162	900	23,673	776	12,643
Dividends left on credit or deposit	3,588	71,409	56,976	1,310,562	5,005	17,165	....	....	....	....
Investment income	35,933	2,101,022	587,703	8,775,725	41,084	299,674	1,084	8,853	33,141	220,844
Extra hazard contributions from the U.S. Government	32	142,332	2,137	4,809,570	....	....	....	....	....	....
Total	47,867	5,166,118	1,294,844	30,986,536	110,269	1,262,412	28,494	301,298	55,810	685,938
DISPOSITION OF INCOME										
Death benefits	34,851	1,435,444	317,777	9,507,044	18,494	246,223	17,166	228,170	13,128	135,035
Matured endowments	484	487,172	38,433	629,085	16,440	16,479	302	2,164	4,486	13,668
Surrender benefits	2,221	316,839	40,335	789,096	4,447	40,147	2,198	16,783	1,794	16,033
Disability benefits	986	365,615	54,259	736,504	2,434	17,816	7,034	73,121	2,431	16,898
Payments from policy proceeds left to be paid in installments	15,815	1,017,315	108,784	7,495,076	1,532	30,862	909	30,899	962	10,757
Dividends withdrawn	4,994	67,188	57,088	1,213,896	2,613	5,386	....	....	....	....
Net deposits for policy reserves	−38,109	480,440	162,101	8,149,617	34,413	610,569	14,717	167,086	22,480	418,889
Reserve for dividends left on credit or deposit	185	39,887	18,989	320,789	3,917	13,412	....	....	....	....
Administrative costs	....	....	....	....	....	....	....	....	681	17,488
Total	21,786	4,109,673	797,328	28,922,687	83,256	982,865	42,986	515,133	46,852	627,988
Net gain (+) or loss (−) from operations before dividends and transfers	26,161	978,445	497,516	11,073,929	26,961	219,547	−14,492	−213,845	8,958	57,950
Dividends to policyholders	27,050	964,418	475,183	10,966,037	30,231	145,974	....	....	....	....
Transfers to U.S. Government	....	....	....	....		56,613	....	....	....	....
Gain (+) or loss (−) after dividends and transfers	−889	12,027	22,333	107,892	−3,270	17,960	−14,492	−213,845	8,958	57,950

In Force — Fiscal Year 1979

Item	Participating: U.S. Government Life Insurance: Number of Policies	Participating: U.S. Government Life Insurance: Amount of Insurance (000 Omitted)	Participating: National Service Life Insurance: Number of Policies	Participating: National Service Life Insurance: Amount of Insurance (000 Omitted)	Participating: Veterans Special Life Insurance: Number of Policies	Participating: Veterans Special Life Insurance: Amount of Insurance (000 Omitted)	Nonparticipating: Service-Disabled Veterans Insurance: Number of Policies	Nonparticipating: Service-Disabled Veterans Insurance: Amount of Insurance (000 Omitted)	Nonparticipating: Veterans Reopened Insurance: Number of Policies	Nonparticipating: Veterans Reopened Insurance: Amount of Insurance (000 Omitted)
In force at beginning of year	116,078	$479,707	3,745,816	$24,405,285	549,995	$4,967,515	181,823	$1,642,900	173,843	$1,208,389
Insurance issued during year	....	....	....	....	....	....	9,926	91,251	....	....
Insurance reinstated during year	6	26	7,978	34,023	492	4,337	57	552	430	1,598
Insurance terminated during year by:										
Death	7,510	34,585	48,514	301,710	2,077	17,993	1,871	18,082	2,023	12,941
Maturity as endowment	97	513	7,087	38,318	3,195	15,318	64	317	706	4,518
Permanent total disability	24	151	....	....	....	....	....	....	....	....
Lapse, expiry, and net changes	132	595	32,516	235,870	17,685	167,130	2,599	25,089	391	5,013
Cash surrender	569	2,470	10,360	58,834	1,020	7,891	904	8,022	441	2,999
Total terminated	8,333	38,293	98,477	634,748	23,977	208,341	5,448	50,021	3,521	25,480
In force at end of year	107,751	441,520	3,665,317	23,806,260	546,500	4,763,511	186,241	1,684,884	170,749	1,184,480
Selected year end items:										
In force on 5 year term plan	566	3,705	1,244,268	9,713,089	314,573	2,883,441	86,813	833,869	....	....
In force on all other plans	107,185	437,816	2,421,049	14,182,170	231,927	1,870,070	99,528	850,815	170,748	1,184,488
In force with disability income rider	2,517	10,765	471,484	3,573,981	92,480	839,744	....	....	10,649	78,482
In force under disability premium waiver	333	1,439	141,032	979,128	6,480	55,968	38,216	380,837	11,050	75,788

TABLE 73

PERSONNEL

Employment: Full, Part-Time and Intermittent by Installation

Installation	Sept. 30, 1979	Sept. 30, 1978
Total	226,084	228,885
Central Office	4,358	4,361
Field	221,726	224,524
Medical Centers (Separate)	174,388	178,407
Domiciliaries and Medical Centers	16,671	16,823
Regional Offices (Separate)	14,867	15,154
Regional Office and Medical Centers	8,985	8,900
Regional Office and Insurance Centers	1,900	1,962
Independent Outpatient Clinics	1,328	1,344
Data Processing Centers	1,897	1,662
National Cemeteries	954	966
Supply Depots and Marketing Center	474	489
Miscellaneous Activities (VCS Field Offices, Prosthetic Center, National Cemetery Area Offices, IG Field Audit Offices)	662	551

TABLE 74

PERSONNEL

Employment: Full, Part-Time and Intermittent by Pay System

Pay System	Sept. 30, 1979	Sept. 30, 1978
Total	226,084	228,885
GS	130,089	132,483
Title 38 (excludes Canteen)	50,810	50,772
Wage System	39,729	40,190
Canteen	3,061	3,087
Nationals (Manila)	221	244
Senior Executive Service	251	....
Others (includes Stay-in-School)	1,453	1,810

TABLE 75

PERSONNEL

Employment: Sex and Veteran Preference—September 30, 1979

	All Employees		Male Employees		Female Employees	
	Number	Percent	Number	Percent	Number	Percent
Total	226,084	100.0	109,430	100.0	116,654	100.0
With Preference	87,130	38.5	77,470	70.8	9,660	8.3
Without Preference	138,954	61.5	31,960	29.2	106,994	91.7

Employment: Minority Groups by Grade—May 31, 1979

Grade or Supervisory Level	Total Employment (Full-time)	Percent Minority Employment	Black	Spanish Surnamed	American Indian	Oriental
Total all pay plans	196,764	30.3	50,035	5,940	424	3,295
GS and equivalent:	157,470	28.8	34,722	4,230	317	3,062
GS-1 thru GS-4	42,044	36.8	13,709	1,260	87	302
GS-5 thru GS-8	54,831	31.8	15,143	1,512	128	840
GS-9 thru GS-11	41,007	17.5	4,894	899	98	1,307
GS-12 and above	19,594	12.2	976	469	24	613
Federal wage systems:	35,396	46.0	14,389	1,544	92	205
Non-supervisory	30,774	46.5	12,667	1,362	81	190
Leader	840	48.1	362	38	3	3
Supervisory	3,646	42.5	1,360	128	8	12
Production facilitating	126	4.8	1	4	...	1
Other wage systems	3,892	28.2	923	160	15	27

Employment of Women—Full-Time and Part-Time
May 31, 1979

Type of Grade of Employment	Total Employment Number	Women	
		Number	Percent Total
Total	220,961	114,847	52.0
GS Total	129,040	71,554	55.5
GS-1-6	85,585	56,689	66.2
GS-7-12	37,716	14,227	37.7
GS-13 and above	5,739	638	11.1
Title 38 (excludes Canteen)	45,297	28,071	62.0
Wage Systems	39,815	10,667	27.3
Canteen	3,510	2,625	74.8
Other (includes Stay-in-School)	1,460	904	61.9

TABLE 78

APPEALS

Advisory Opinions Requested by the Board of Veterans Appeals from Outside Medical Experts

Medical Specialty	Number of Advisory Opinions Requested	
	Fiscal Year 1978	Fiscal Year 1979
All Specialties	201	225
Number requested in connection with:		
Appellate consideration	175	210
Reconsideration	26	15
Internal Medicine:		
General	9	8
Cardiovascular	20	27
Gastroenterology	8	8
Pulmonary diseases	8	8
Surgery:		
General	3	2
Orthopedic	11	11
Thoracic	0	0
Otolaryngology & Ophthalmology	4	9
Psychiatry	60	73
Neurology-Medical and/or Surgical	24	20
Pathology-Medical and/or Surgical	43	42
Other	11	17

TABLE 79

APPEALS

Analysis of Cases Decided by Board of Veterans Appeals
Fiscal Year 1979

Benefits Involved	Cases				
	Total	Allowed	Denied	Remanded	Withdrawn
Total	34,872	4,431	25,543	4,761	217
Disability	29,209	3,780	21,339	3,963	164
Death	2,487	361	1,704	412	10
Insurance and indemnity	175	7	154	13	1
Education and training	1,026	108	835	75	8
Loan guaranty, waiver of indebtedness	268	33	175	58	2
Waiver and forfeiture	1,014	122	750	124	18
Medical treatment and reimbursement	514	33	372	98	11
Reconsideration	225	25	182	15	3
Character of discharge	77	12	52	13	0

Period of Service	Cases				
	Total	Allowed	Denied	Remanded	Withdrawn
Total	34,872	4,431	25,563	4,761	217
WWI	377	46	282	43	6
WWII	16,866	1,889	12,678	2,170	121
Korean conflict	4,876	596	3,562	597	21
Vietnam era	10,348	1,583	7,082	1,620	60
Regular establishment	2,423	336	1,782	300	6
Other	283	60	187	31	3

VA Gross Expenditures[1]—Fiscal Years 1970–1979

Fiscal Year	Grand Total	Medical and Administrative Expenses					Hospital and Domiciliary Construction Costs	Construction Grants for State Homes	Health Manpower Training Facilities	National Cancer Institute (transfer to VA)
		Total	Medical Care	General Operating Expenses	Medical and Prosthetic Research	Medical Administration Expenses				
1979	$22,178,870,841	$ 6,205,941,745	$ 5,408,251,895	$ 625,740,917	$ 125,577,137	$ 48,371,796	$ 240,304,876	$ 14,190,947	$ 38,321,902	....
1978	20,937,106,741	5,683,811,348	4,948,297,375	575,213,971	117,563,185	42,736,815	245,081,811	5,031,278	38,143,438	....
1977	20,284,739,028	5,072,993,821	4,402,752,024	522,061,364	108,745,374	39,435,059	224,546,309	3,670,801	33,875,869	....
T.Q. 9-30-76	4,524,304,469	1,195,770,956	1,033,503,297	123,644,946	27,373,991	11,248,723	49,196,439	2,064,709	3,749,462	....
1976	20,167,672,990	3,996,766,600	3,831,942,636	479,213,633	101,130,244	34,479,087	185,569,710	11,616,975	26,950,826	....
1975	18,002,858,465	3,919,256,993	3,348,139,083	438,660,271	95,794,770	36,662,859	119,579,730	3,153,684	12,926,229	....
1974	15,281,999,263	3,290,194,883	2,833,322,391	343,916,390	81,581,682	31,034,411	106,364,406	2,484,814	....	....
1973	13,973,824,241	2,966,237,960	2,545,676,531	317,104,838	78,412,475	25,044,116	92,635,174	2,448,163	....	....
1972	12,723,327,251	2,650,982,373	2,280,185,623	280,516,258	68,958,723	22,321,769	107,335,950	2,563,280	....	$ 70[2]
1971	11,565,101,689	2,256,979,848	1,913,508,523	260,148,750	63,138,662	20,185,883	80,919,238	4,168,114	....	27,379
1970	10,201,210,179	2,007,783,909	1,687,622,806	243,024,802	59,354,767	17,781,534	71,153,768	3,451,576	....	1,020,531

Fiscal Year	Compensation and Pension									
	Total	Compensation and Pensions	Statutory Burial Awards	Clothing Allowances[3]	Mortgage and Group Insurance	Interment and Plot Awards[4]	Invalid Lifts, Devices, and Polio Rentals[3]	Headstones Markers and Burial Flags[3]	Tort Claim Settlements	Other[3]
1979	$10,640,134,325	$10,324,258,064	$ 94,218,175	$ 13,763,407	$ 4,280,424	$ 50,436,396	$ 12,306,114	$ 15,243,853	....	$ 25,847,892
1978	9,630,679,653	9,455,752,982	85,881,083	12,709,134	2,600,000	51,369,656	7,497,994	13,469,609	....	1,390,195
1977	9,038,803,014	8,874,719,650	80,034,069	11,471,325	2,844,000	47,647,486	6,630,520	14,050,489	....	1,405,495
T.Q. 9-30-76	2,087,912,845	2,040,460,373	19,849,033	9,524,356	1,283,940	11,886,226	1,557,711	3,348,447	....	760[5]
1976	8,242,098,546	8,074,488,426	130,505,883	10,623,546	3,740,397	....	6,361,164	13,079,492	....	3,289,638
1975	7,561,176,877	7,386,070,190	130,590,145	8,794,394	1,600,000	....	5,304,048	13,007,763	....	6,810,337
1974	6,734,790,004	6,615,598,931	101,607,089	740,193	2,200,000	....	3,929,569	2,644,410	$ 1,228	8,068,574
1973	6,568,081,137	6,426,646,756	77,701,419	759,462	1,249,917	48,959,907	3,340,854	2,559,306	16,324	6,848,192
1972	6,167,996,446	6,045,214,262	75,753,044	663,017	1,850,000	42,051,401	3,007,622	2,257,664	37,254	2,837,818[2]
1971	5,839,390,281	5,726,457,889	69,644,373	603,653	....	39,561,067	2,541,021	2,005,881	92,616	1,518,219[2]
1970	5,357,407,811	5,253,839,611	73,386,181	572,948	....	27,886,405	1,459,708	1,542,930	172,400	1,490,304

Fiscal Year	Educational Assistance and Readjustment Benefits									
	Total[7]	Post-Korean Veterans (Ch. 34) Educational Assistance	Dependents (Chapter 35) Educational Assistance	Vocational Rehabilitation (Ch. 31, Books, Supplies, etc.)	Subsistence Allowance (Voc. Rehab. Chapter 31)[6]	Automobiles, etc., for Disabled Veterans	Housing for Paraplegic Veterans	Changes in Receivables	Direct Loans to Veterans	Loan Guaranty Revolving Fund
1979	$ 2,800,897,985	$ 2,449,924,173	$ 204,061,042	$ 32,333,777	$ 64,071,085	$ 12,467,080	$ 22,607,775	$ 15,212,423	$ 57,375,851	$ 453,021,818
1978	3,336,618,918	3,026,928,408	216,981,694	32,767,736	67,285,440	13,757,956	14,299,169	35,409,387[2]	73,296,267	514,097,630
1977	3,891,448,932	3,567,244,475	202,161,069	32,679,339	69,016,591	13,306,986	14,254,830	6,214,377[2]	96,587,591	520,808,342
T.Q. 9-30-76	738,178,540	667,905,838	28,229,889	6,800,966	13,454,828	3,446,085	3,351,014	14,989,911	19,169,327	116,296,760
1976	5,543,364,200	5,028,843,709	185,582,673	27,502,222	58,077,759	19,073,015	14,553,425	209,721,398	89,849,371	483,799,919
1975	4,529,227,472	4,164,774,846	163,277,716	22,500,293	50,565,594	17,251,021	14,322,011	96,535,991	83,994,161	422,549,564
1974	3,268,556,875	3,005,746,476	115,546,256	22,593,495	45,151,941	5,005,086	11,254,178	63,259,444	81,881,265	449,102,006
1973	2,696,239,516	2,513,214,849	99,879,139	22,995,825	48,959,907	6,799,579	12,890,667	40,469,457	104,064,742	372,580,455
1972	1,935,797,731	1,812,434,284	76,631,860	22,937,790	42,051,401	10,539,775	7,069,429	6,186,593	113,126,877	322,052,753
1971	1,631,738,617	1,521,699,607	70,644,290	19,168,047	39,561,067	6,642,229	8,016,871	5,567,574	147,134,261	298,240,129
1970	1,018,861,723	938,775,099	51,927,780	13,776,262	27,886,405	5,856,799	7,785,818	738,965	180,403,169	248,981,391

Fiscal Year	Insurance and Indemnities								
	U.S. Government Life Insurance	National Service Life Insurance	Veterans Special Life Insurance	Service-disabled Veterans Insurance	Veterans Reopened Insurance	Servicemen's Group Life Insurance Fund	Servicemen's Indemnities	Military and Naval Insurance	Soldiers' and Sailors' Civil Relief
1979	$ 84,386,143	$1,109,598,880	$ 77,173,601	$ 26,108,088	$ 29,240,377	$ 106,853,382	$ 3,080	$ 468,000	$ 630
1978	70,401,833	746,611,702	29,913,010	21,547,719	21,977,982	118,539,000	1,000	967,000	3,178
1977	76,022,139	763,278,062	28,307,779	21,303,447	21,367,900	118,089,380	5,574	988,788	6,696
T.Q. 9-30-76	15,204,568	168,012,046	7,080,537	6,077,138	5,396,324	25,927,221	2,786	181,462	....
1976	88,805,893	949,901,617	38,287,348	23,150,102	22,218,746	128,001,104	191	752,714	9,417
1975	104,128,105	1,028,933,065	34,256,489	22,388,582	21,672,793	132,272,330	9,478	887,627	2,078
1974	98,209,929	879,961,278	25,758,014	21,346,577	19,389,713	83,241,810	4,288	1,008,428	4,887
1973	85,586,286	735,086,715	24,346,142	20,082,876	18,406,675	79,426,528	28,827	1,090,058	2,802
1972	104,217,986	958,006,040	22,629,652	18,909,389	16,021,871	113,341,078	5,083	1,227,406	9,967
1971	101,057,270	860,289,965	22,063,259	17,580,247	14,710,802	163,988,014	743	1,362,480	10,318
1970	106,865,265	877,790,136	21,910,442	23,847,187	13,588,911	135,216,033	18,443	1,519,093	2,530

Fiscal Year	Miscellaneous Funds and Expenditures								
	Vocational Rehabilitation Revolving Fund	Grants to The Republic of The Philippines	Construction Corregidor-Bataan Memorial	Rental Maintenance and repair of quarters	Supply Fund	General Post Fund	Consolidated Working Fund	All Others	
1979	$ 986,491	$ 268,790	....	....	$ 389,165,552	$ 5,600,648	....	....	
1978	1,007,173	1,672,105	....	....	382,897,095	5,030,407	$ 1,177,107	....	
1977	982,382	2,013,640	....	$ 387	364,926,821	4,374,619	1,558,753	....	
T.Q. 9-30-76	242,704	543,402	....	61,709	90,745,157	1,063,626	598,754	....	
1976	833,532	1,869,576	....	217,101	330,636,825	4,661,975	1,531,704	....	
1975	982,277	2,019,325	....	206,370	8,554,095	3,912,065	1,059,537	....	
1974	884,041	1,952,900	....	200,342	213,261,928	3,674,147	796,146	....	
1973	627,319	1,816,967	$ 37,626	179,495	199,030,568	3,171,917	602,089	$ 841,348	
1972	378,464	1,954,474	....	180,281	182,937,825	2,603,560	419,866	556,150	
1971	351,056	1,652,300	761	142,653	190,744,832	2,480,082	514,386	649,364	
1970	302,370	1,454,083	76,138	101,842	125,988,436	2,383,790	174,000	600,000	

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[1] *Data are on an accrued expenditures basis.*

[2] *Credit.*

[3] *Clothing Allowance, Polio Rentals, Headstones/Markers included in their respective columns beginning with FY 1975, previously included under "All Others."*

[4] *Reported separately for the first time Transition Quarter ending 9/30/76.*

[5] *Changes in receivables and WWI adjusted service certificates. TQ 9/30/76 WWI adjusted service certificates only.*

[6] *Data for FY 1973 and prior years included in Compensation and Pension appropriations.*

[7] *Includes 230,620 for Post Vietnam Era Veterans Educational Assistance (Chapter 32).*

Appropriations, Expenditures and Balances—Cash Basis

	Appropriations	Expenditures		Nonexpenditure Transfers	Covered into U.S. Treasury or restored	Investments	Cash Balance
		Fiscal Year 1979	Cumulative through September 30, 1979				
General and special funds:							
Compensation and pensions	162,571,847,000	10,441,938,402	161,587,419,942	16,900	......	......	874,264,030
Readjustment benefits	57,219,122,904	2,810,811,988	56,979,020,257	*81,700,000	......	......	148,388,647
Veterans insurance and indemnities	368,905,036	4,421,173	403,877,518	49,748,500	......	......	2,274,019
Medical care, Current Year	5,374,374,000	4,597,508,463	4,597,508,463	......	4,983,227	......	772,084,310
Medical care, 1954 – 78	45,232,100,226	581,977,488	44,573,450,378	......	610,435,562	......	48,214,284
Medical and prosthetic research	1,184,560,131	117,270,078	1,150,788,581	......	......	......	34,772,530
Assistance for health manpower training institutions, 1973 – 85	296,893,000	40,671,612	145,829,243	......	6,160	......	150,857,587
Medical administration and miscellaneous operating expenses, Current Year	47,088,000	36,079,098	36,079,098	......	711,030	......	10,297,272
Medical administration and miscellaneous operating expenses, 1954 – 78	620,958,401	8,841,290	590,151,467	......	29,554,113	......	1,253,810
General operating expenses, Current Year	631,675,000	552,713,481	552,713,481	......	7,940,780	......	71,020,770
General operating expenses, 1954 – 78	6,356,831,650	50,581,774	6,261,083,817	......	86,247,200	......	9,500,633
Construction of hospital and domiciliary facilities	1,042,586,863	......	1,032,915,865	*9,681,000	......	......	......
Construction, major projects	1,923,717,000	150,231,501	774,213,602	7,734,700	......	......	1,157,238,198
Construction, minor projects	544,198,000	86,295,400	381,060,708	2,018,442	......	......	165,117,850
Construction, minor projects (Corps of Engineers)	......	......	2,128,796	2,128,796	......	......	......
Grants for construction of state extended care facilities, 1966 – 80	94,700,000	14,303,188	62,030,028	......	1,513,258	......	31,156,714
Grants to the Republic of the Philippines	763,000	41,174	678,242	......	......	......	84,758
Grants to the Republic of the Philippines, Current Year	480,000	22,431	22,431	......	223,599	......	233,970
Grants to the Republic of the Philippines, 1950 – 1978	49,070,537	123,508	36,032,483	......	13,006,731	......	31,344
Loan Guaranty revolving fund	32,420,742	207,111,882	612,386,951	1,088,023,329	......	......	270,048,118
Direct Loan revolving fund	1,733,056,500	*65,388,431	*854,929,940	*1,796,337,270	......	......	831,649,201
Canteen service revolving fund	4,965,000	*3,250,021	*24,178,985	......	12,008,000	......	17,075,890
Rental, maintenance and repair of quarters	......	......	*97,127	......	97,127	......	......
Service-disabled veterans insurance fund	4,500,000	882,702	*1,687,143	......	......	......	6,187,144
Soldiers' and sailors' civil relief	3,539,000	......	2,011,031	*16,000	1,500,000	......	......
Veterans reopened insurance fund	......	*27,890,000	*438,427,400	......	......	437,950,000	477,400
Special Therapeutic and Rehabilitation Activities Fund	......	*163,840	*400,568	......	......	......	400,568
Vocational rehabilitation revolving fund	2,197,000	23,238	474,877	......	1,600,000	......	122,122
Education Loan Fund	......	6,367,403	61,332,695	91,700,000	......	......	30,370,305
Servicemen's group life insurance fund	......	463,871	......	......	......	......	......
Supply fund	130,000,000	*7,895,852	12,187,712	*71,400	15,077,579	......	102,663,310
Consolidated working fund	......	2,633	*1,300,000	......	......	......	1,300,000
Total: appropriations and funds	275,467,087,109	19,582,142,896	269,933,517,958	*648,438,851	788,384,431	437,950,000	4,651,395,937
Deduct proprietary receipts from the public	......	3,820,896	......	......	......	......	......
Total: federal funds	275,467,087,109	19,578,321,990	269,933,517,958	*648,438,851	788,384,431	437,950,000	4,651,395,937
Trust funds:							
Post Vietnam Era Veterans Education	105,843,787	13,814,563	13,814,563	......	......	......	92,010,720
General post fund, national homes	82,479,081	5,546,620	72,687,637	......	386	2,365,000	7,425,970
National service life insurance fund	30,838,106,000	785,392,058	22,888,941,145	......	90	7,960,952,000	7,212,767
U.S. government life insurance fund	3,893,444,236	70,841,204	3,427,288,780	......	1,811,190	462,557,000	1,786,247
Veterans special life insurance fund	260,000	38,048,562	*677,279,706	*51,150,000	4,250,000	621,135,000	984,706
Sub-Total: Trust funds	34,918,123,024	837,546,572	25,786,462,933	*51,150,000	6,061,674	9,046,009,000	109,430,410
Deduct: Proprietary receipts from the public	......	526,327,765	......	......	......	......	......
Total: trust funds	34,918,123,024	311,218,817	25,786,462,933	*51,150,000	6,061,674	9,046,009,000	109,430,410
Deduct: intragovernmental transactions	......	2,138,973	......	......	......	......	......
Total: Veterans Administration	310,375,810,183	19,887,401,834	294,638,980,881	*697,588,851	794,446,105	9,483,959,000	4,760,835,356
Appropriations and funds not included above:							
Personal funds of patients	......	*1,088,016	*59,104,280	......	......	......	59,104,280
Funds due incompetent beneficiaries	......	17,021	*42,880	......	......	......	42,880
Miscellaneous administrative and construction expenses	10,856,083,780	......	10,476,102,823	......	379,980,958	......	......
Miscellaneous benefit and insurance expenses	25,110,301,012	......	24,621,740,653	......	488,560,359	......	......
Miscellaneous trust funds	4,700,042,383	......	4,658,821,650	......	42,220,735	......	......
Miscellaneous transfer appropriations and working funds	38,634,996	......	31,269,691	......	7,365,305	......	......
Total: Other appropriations and funds	40,704,062,190	*993,397	39,728,587,500	......	917,127,355	......	59,146,957

*Indicates Credit

TABLE 82 FISCAL

Veterans Administration Comparative Consolidated Balance Sheet[1]

ASSETS	September 30, 1979	September 30, 1978	Increase (Decrease)
Current assets:			
Cash and disbursing authority[2]	$ 4,834,716,912.59	$ 4,851,616,473.70	$..........
Accounts receivable	534,836,790.86	484,061,880.71	....
Interest receivable	280,965,496.24	183,521,979.45	....
Advance for bidding at public sales	322,507.05	262,337.07	....
Inventories	118,306,215.19	106,587,298.08	....
Acquired security or collateral property	230,070,480.33	231,113,739.04	....
Accrued reimbursements due from insurance appropriations			....
Total current assets	5,999,216,421.86	5,657,227,908.85	341,988,513.01
Other assets:			
Loan receivable	1,783,844,582.01	1,753,085,746.02	....
Vendee accounts receivable	1,216,086,147.90	988,302,330.16	....
Investments	9,483,980,000.00	9,244,406,000.00	....
Policy liens	771,530.00	757,013.33	....
Deposits with trustee	87,338,067.56	96,852,980.54	....
Total other assets	12,572,009,327.46	12,083,983,060.05	488,026,266.41
Fixed assets:			
Land, buildings and plants	2,722,075,123.66	2,688,633,240.13	....
Construction and betterments in process	803,035,867.40	631,325,788.63	....
Leasehold improvements	2,830,680.36	2,677,280.66	....
Equipment	1,216,008,176.16	1,080,909,853.29	....
Total Fixed assets	4,743,907,856.57	4,303,546,132.71	430,962,723.86
Deferred charges:			
Construction advance	11,861,586.46	13,644,911.38	....
Advance payments on undelivered supplies and services	38,880,157.38	34,060,026.30	....
Advance to employees for travel expenses	2,208,193.60	1,872,321.14	....
Value of ADP equipment purchase options	4,060,502.01	3,616,307.87	....
Advance for educational benefits	17,366,271.08	21,996,401.90	....
Total deferred charges	71,976,679.55	75,898,138.66	(3,921,469.11)
Total assets	23,296,710,284.64	22,120,653,838.47	1,176,056,446.17
LIABILITIES AND CAPITAL			
Current liabilities:			
Accounts payable	1,301,864,084.86	1,108,827,273.53	....
Accrued salaries and wages	82,411,377.47	79,363,914.98	....
Accrued annual leave - Canteen Service			....
Accrued services and benefits	303,802,087.19	217,413,515.81	....
Undelivered orders - personal funds of patients	121,088.96	124,894.42	....
Employee payroll allotments for U.S. Savings Bonds	1,297,275.21	1,486,983.90	....
Federal, state, city and territorial income taxes withheld and FICA taxes	10,567,934.80	11,835,256.70	....
Canteen Service unredeemed coupons	114,895.69	112,834.99	....
Other miscellaneous liabilities - Canteen Service	....	....	....
Accrued interest - U.S. Treasury	2,010,380.16	1,734,818.47	....
Accrued interest on policy liens due general fund	77,187.15	81,966.40	....
Accrued interest on divident deposits	9,817,321.87	8,909,416.93	....
Premiums paid on advance	95,945,000.00	82,380,100.00	....
Matured contracts payable	35,824,928.02	32,343,213.38	....
Undeposited general fund receipts	1,101,522.01	1,120,080.87	....
Total current liabilities	1,984,635,432.59	1,804,762,263.01	179,873,169.58
Other liabilities:			
Participation certificates outstanding, net	426,068,748.28	587,768,885.19	....
Insurance program operating reserves	9,239,975,207.00	10,106,507,094.00	....
Total other liabilities	9,665,043,955.28	10,694,275,979.19	(829,232,023.91)
Unfunded liabilities:			
Accrued annual leave	351,608,464.70	325,332,888.74	....
Unredeemed coupons	267,476.41	267,476.41	
Total unfunded liabilities	351,875,931.11	325,600,365.15	26,275,565.96
Total liabilities	11,821,565,318.96	12,594,638,608.25	(773,083,289.29)
Accountabilities:			
Funds of patients and incompetent beneficiaries	57,096,570.21	56,613,080.99	....
Policyholders insurance dividend deposit	344,950,325.85	328,961,305.10	....
Borrowers deposits for taxes and insurance	52,107,784.97	49,370,421.21	....
Unapplied insurance collections	2,037,195.10	1,377,834.71	....
Bid deposits and other suspense items	15,948,813.82	14,854,591.72	....
Total accountabilities	472,740,689.95	451,177,013.73	21,563,686.22
Capital reserves:			
Direct loan and loan guaranty programs - reserve for losses	718,271,922.99	674,705,982.61	....
Total reserves	718,271,922.99	674,705,982.61	43,565,940.38
Capital borrowings from U.S. Treasury - interest bearing - direct loan program	1,730,077,986.00	1,730,077,986.00	....
Capital residual	8,564,064,376.74	6,670,054,237.88	1,894,010,138.86
Total liabilities and capital	$23,296,710,284.64	$22,120,653,838.47	$ 1,176,056,446.17

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[1] *Contingent liabilities with respect to the guaranty of insurance of loans not shown.*

[2] *Cash and disbursing authority for annual appropriations reduced by the unobligated balance return to the Treasury in accordance with Section 18, Title 7, GAO Policy and Procedures Manual.*

VA Supply Fund Comparative Balance Sheet

ASSETS	September 30, 1979	September 30, 1978	Increase (Decrease)
Cash	$102,083,300.75	$ 94,447,457.38	$
Advance payments on undelivered orders	238,206.10	610,330.09	
Advances to employees	12,500.26	21,918.61	
Accounts receivable	15,733,850.60	16,716,241.08	
Inventories	91,230,204.77	88,705,326.04	
Work in process - Service & Reclamation division	58,441.48	66,464.53	
Work in process - Printing & Reproduction	18,774.84	19,335.00	
Supply Depot operating equipment less reserve for depreciation	825,196.60	682,050.90	
Printing & Reproduction equipment less reserve for depreciation	474,440.46	314,471.14	
Marketing center equipment less reserve for depreciation	67,154.23	20,982.60	
Total Assets	210,741,159.41	201,713,488.20	9,027,671.21
LIABILITIES AND CAPITAL			
Accrued salaries and wages	347,323.76	323,846.88	
Accrued transportation and service costs	525,037.56	402,867.12	
Accounts payable	36,994,961.36	28,082,288.83	
Advances from other government agencies	219,553.31	348,762.94	
Total Liabilities	38,086,875.99	29,157,765.77	8,929,110.22
Capital at beginning of period	151,250,550.73	151,250,550.73	
Transfer of Inventories from GSA	1,697,521.19	1,697,521.19	
Property acquired without cost to VA	50,808.20		
Appropriation realized	20,000,000.00	20,000,000.00	
Adjusted capital	172,998,880.12	172,948,071.92	
Operating profit or loss* - Current fiscal year	392,340.49*	258,808.40*	
Operating profit or loss* - prior fiscal year	47,754.79	133,541.09*	
Capital at end of period	172,654,283.42	172,555,722.43	98,560.99
Total Liabilities and Capital	$210,741,159.41	$201,713,488.20	9,027,671.21

VA Supply Fund—Statement of Income and Expense
Fiscal Year 1979

INCOME		
Sales of supplies and equipment		$381,528,577.14
Less: Cost of Goods sold		374,289,785.77
Income on Sales		7,238,791.37
Other Income:		
Income-station transfers	$5,675,458.45	
Discounts on purchases	2,481,861.47	
Reimbursable earnings	3,469,142.70	
Donated income	2,340,103.02	
Credit allowances	1,309,814.58	
Variances and adjustments	66,543.31	
Increased valuation	170,720.48	
Miscellaneous income	131,580.39	15,635,024.40
Total income		22,873,815.77
EXPENSES		
Maintenance and operation of supply depots		8,287,880.24
Other operating expenses		8,796,586.94
Net transportation costs		3,167,162.16
Completed S&R projects		1,466,103.84
Depot storage, handling, etc.		421,702.79
Donations, reappraisals and Write offs		645,162.85
Disposal of operating equipment		21,453.59
Total expense		22,826,060.98
Operating Profit		$ 47,754.79

Estimated Selected Expenditures by State—Fiscal Year 1979

State	Total Expenditures All Programs	Readjustment Benefits							
		Total		Educational Assistance					
				Post-Korean Conflict Veterans (Title 38, U.S.C., Ch. 34)		Sons and Daughters of Deceased & Totally Disabled Veterans (Title 38, U.S.C., Ch. 35)		Widows/Widowers and Spouses of Totally Disabled Veterans (Title 38, U.S.C., Ch. 35)	
		Total Number Who Trained During Year	Amount	Total Number Who Trained During Year	Amount	Total Number Who Trained During Year	Amount	Total Number Who Trained During Year	Amount
World Totals	$20,730,116,517	1,410,[illegible]¹	$2,[illegible]	1,278,530	2,[illegible],173	[illegible]	178,[illegible]	17,[illegible]	27,[illegible],148
Philippines	105,224,[illegible]	5,[illegible]	13,647,[illegible]	2,[illegible]	10,[illegible]	2,[illegible]	3,107,[illegible]	154	93,[illegible]
Other foreign areas	19,[illegible]	1,[illegible]	13,[illegible],720	1,117	12,[illegible],141	185	[illegible]	13	21,[illegible]
Puerto Rico	257,226,[illegible]	10,230	28,321,452	7,[illegible]	20,737,[illegible]	2,[illegible]	[illegible]	[illegible]	[illegible]
Other U.S. areas	3,[illegible],911	770	677,870	145	621,436	26	16,[illegible]	3	8,135
Total U.S.	[illegible]	1,[illegible]	[illegible]	1,[illegible]	2,[illegible]	[illegible]	[illegible]	16,[illegible]	[illegible]
Alabama	411,504,752	37,[illegible]	75,[illegible]	33,[illegible]	66,242,701	2,407	4,[illegible]	570	[illegible]
Alaska	39,079,713	3,120	4,331,357	3,[illegible]	4,164,273	60	160,138	7	5,728
Arizona	305,232,[illegible]	30,[illegible]	57,[illegible],070	27,775	49,076,173	2,104	4,073,257	507	[illegible]
Arkansas	315,917,053	16,[illegible]	[illegible]	14,470	31,529,[illegible]	1,272	2,940,138	277	[illegible]
California	1,[illegible],027,722	192,073	[illegible],015,[illegible]	179,801	331,204,[illegible]	[illegible]	17,[illegible]	2,[illegible]	3,[illegible]
Colorado	272,[illegible],601	27,170	[illegible]	24,140	47,023,[illegible]	1,510	3,034,[illegible]	315	[illegible]
Connecticut	207,795,[illegible]	13,700	24,224,335	12,[illegible]	21,729,621	545	1,153,[illegible]	77	[illegible]
Delaware	52,007,010	4,[illegible]	[illegible],652,[illegible]	3,740	5,872,019	183	[illegible]	26	[illegible]
District of Columbia	528,513,[illegible]	15,[illegible]	8,534,570	14,271	[illegible]	384	526,212	75	77,233
Florida	1,112,170,[illegible]	[illegible],774	147,[illegible],177	61,222	124,[illegible],773	[illegible]	12,[illegible]	1,740	2,[illegible]
Georgia	[illegible],027,714	[illegible]	82,277,131	38,145	70,817,[illegible]	2,[illegible]	[illegible],101,777	[illegible]	1,140,104
Hawaii	[illegible],017	12,535	21,011,537	11,[illegible]	18,827,525	479	1,[illegible]	118	[illegible]
Idaho	71,757,[illegible]	[illegible],977	11,[illegible]	[illegible]	10,[illegible]	[illegible]	[illegible]	[illegible]	97,[illegible]
Illinois	[illegible]	[illegible]	[illegible]	46,[illegible]	[illegible]	1,[illegible]	2,975,257	[illegible]	310,323
Indiana	352,721,[illegible]	24,353	47,141,710	22,332	41,[illegible],443	[illegible]	1,[illegible],516	100	137,[illegible]
Iowa	234,130,[illegible]	12,434	[illegible]	11,[illegible]	23,240,[illegible]	[illegible]	1,[illegible]	[illegible]	73,[illegible]
Kansas	215,217,[illegible]	14,447	[illegible],574	13,[illegible]	[illegible],075	[illegible]	1,[illegible]	111	174,[illegible]
Kentucky	335,[illegible],132	18,511	41,131,204	16,[illegible]	[illegible],132,[illegible]	1,207	2,[illegible],033	[illegible]	315,047
Louisiana	[illegible] 743,013	[illegible]	44,117,119	[illegible]	[illegible],616,[illegible]	1,[illegible]	[illegible]	[illegible]	418,[illegible]
Maine	130,[illegible]	[illegible]	17,[illegible]	7,[illegible]	15,[illegible]	[illegible]	1,[illegible]	[illegible]	174,[illegible]
Maryland	291,[illegible],233	[illegible]	[illegible]	[illegible],777	37,[illegible]	1,[illegible]	2,[illegible]	279	318,543
Massachusetts	[illegible],449,542	32,330	[illegible],812,[illegible]	[illegible],710	[illegible],482,515	2,[illegible]	5,015,[illegible]	[illegible]	[illegible]
Michigan	578,571,513	41,[illegible]	[illegible]	[illegible],735	[illegible]	1,[illegible]	3,[illegible],033	[illegible]	475,[illegible]
Minnesota	[illegible],045	22,712	47,575,[illegible]	21,179	43,482,013	1,024	2,104,[illegible]	[illegible]	123,[illegible]
Mississippi	272,[illegible]	12,[illegible]	[illegible],014,918	[illegible]	[illegible]	1,[illegible]	[illegible],112	[illegible]	[illegible]
Missouri	[illegible],190,914	[illegible]	[illegible]	[illegible]	[illegible]	1,[illegible]	2,[illegible]	291	314,[illegible]
Montana	75,772,[illegible]	5,[illegible]	9,[illegible]	4,847	8,[illegible]	[illegible]	[illegible]	43	[illegible],222
Nebraska	147,401,[illegible]	12,179	23,[illegible],112	11,[illegible]	20,707,[illegible]	614	1,[illegible],132	[illegible]	147,[illegible]
Nevada	71,482,453	6,[illegible]	11,[illegible],419	6,[illegible]	10,[illegible],276	232	[illegible]	[illegible]	102,[illegible]
New Hampshire	[illegible],618,[illegible]	6,711	14,052,[illegible]	5,[illegible]	11,[illegible]	[illegible]	677,[illegible]	[illegible]	[illegible]
New Jersey	[illegible]	24,107	47,183,291	22,[illegible]	[illegible]	1,172	3,017,[illegible]	224	[illegible],472
New Mexico	151,[illegible],102	11,519	24,[illegible],952	10,143	20,[illegible]	[illegible]	1,[illegible]	100	275,[illegible]
New York	1,[illegible],191	[illegible],421	112,[illegible]	[illegible]	[illegible]	4,[illegible]	[illegible],043,971	[illegible]	[illegible]
North Carolina	[illegible],552,[illegible]	[illegible]	[illegible]	[illegible]	[illegible],351,429	2,[illegible]	6,204,[illegible]	[illegible]	1,174,[illegible]
North Dakota	53,107,[illegible]	4,[illegible]	[illegible]	4,[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Ohio	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1,[illegible]	2,[illegible]	[illegible]	[illegible]
Oklahoma	[illegible]	[illegible]	[illegible],730	[illegible]	[illegible]	2,[illegible]	[illegible]	[illegible]	[illegible],441
Oregon	[illegible]	18,[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1,[illegible],122	[illegible]	[illegible]
Pennsylvania	[illegible],407,[illegible]	47,[illegible]	[illegible],191,[illegible]	[illegible]	[illegible]	2,[illegible]	[illegible],671	271	[illegible]
Rhode Island	102,[illegible]	[illegible]	12,746,411	5,842	10,[illegible]	[illegible]	[illegible]	[illegible]	75,[illegible]
South Carolina	[illegible],014	[illegible],717	[illegible],112	27,482	[illegible],131,[illegible]	1,[illegible]	3,120,135	[illegible]	[illegible]
South Dakota	[illegible],377	5,010	10,[illegible]	4,400	[illegible]	[illegible]	570,346	[illegible]	[illegible],216
Tennessee	[illegible],033	[illegible],627	[illegible]	[illegible]	[illegible]	1,[illegible]	3,370,[illegible]	[illegible]	461,[illegible]
Texas	1,[illegible],743,873	[illegible],475	[illegible],729,[illegible]	[illegible]	[illegible],750,713	7,[illegible]	16,762,077	1,[illegible]	[illegible]
Utah	112,207,531	10,[illegible]	21,[illegible],434	9,170	10,[illegible],217	610	1,[illegible]	[illegible]	120,[illegible]
Vermont	[illegible]	1,[illegible]	2,[illegible]	1,[illegible]	2,[illegible]	[illegible]	[illegible]	[illegible]	10,[illegible]
Virginia	[illegible],077,[illegible]	[illegible]	77,[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Washington	[illegible],218,[illegible]	33,073	70,027,[illegible]	30,718	61,357,373	2,103	4,[illegible]	[illegible]	[illegible]
West Virginia	201,017,[illegible]	11,[illegible]	[illegible]	10,[illegible]	10,[illegible]	[illegible]	1,110,[illegible]	[illegible]	102,742
Wisconsin	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1,[illegible]	2,[illegible]	116	[illegible],175
Wyoming	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	201,[illegible]	[illegible]	52,[illegible]

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¹Excludes the following which are not distributable by State: adjusted service and dependents pay; [illegible] burial awards and burial flags; [illegible] (section [illegible], title 38 U.S.C.); [illegible] devices, equipment, etc.; [illegible] to National Cancer Institute; vocational rehabilitation revolving fund; loan guaranty revolving fund; rental, maintenance and repair of quarters; supply revolving fund; and personal funds of patients.

TABLE 95 Continued

Estimated Selected Expenditures by State—Fiscal Year 1979

State	Readjustment Benefits—Continued: Vocational Rehabilitation: Subsistence, Equipment and Supplies, Books and Tuition (Title 38, U.S.C., Ch. 31): Total Number Who Trained During Year	Amount	Automobiles and Other Conveyances for Disabled Veterans	Homes for Paraplegics	Direct Loans	Insurance and Indemnities	Hospital and Domiciliary Construction[1]	Medical Services and Administrative Costs
World Totals	29,470[2]	$ [illegible]	$ 12,437,446	$ 22,887,775	$ 47,770,210	$1,[illegible]	$284,377,102	$6,[illegible]
Philippines	3	28,887	14,700	....	....	2,000,857	....	2,102,000
Other foreign areas	26	1,000	....	....	....	3,070,203	....	....
Puerto Rico	580	1,340,535	100,842	142,700	11,840	1,710,183	840,000	60,841,012
Other U.S. areas	2	1,000	....	....	....	381,467	....	....
Total U.S.	28,902	$ [illegible]	$ 12,313,000	$ 22,466,917	$ 47,707,870	$1,[illegible]	$284,730,[illegible]	$6,104,204,601
Alabama	800	3,306,270	243,246	620,714	38,096	12,984,920	2,400,525	112,572,807
Alaska	37	80,831	370	....	....	422,479	....	15,190,785
Arizona	470	1,573,984	441,384	536,000	33,773	16,546,567	1,354,814	84,892,231
Arkansas	201	1,015,121	200,579	349,457	1,548,712	10,770,210	4,485,812	84,164,455
California	1,[illegible]	5,404,724	1,324,565	1,944,545	20,705	117,982,804	12,084,670	[illegible]
Colorado	1,187	4,414,800	204,924	471,000	....	14,804,779	2,212,793	77,148,511
Connecticut	318	884,572	142,011	238,333	....	17,651,089	588,775	68,009,785
Delaware	108	380,985	44,000	....	50,000	2,833,423	50,130	21,286,149
District of Columbia	385	720,965	108,040	200,000	9,531,100	6,776,626	25,812,775	435,501,285
Florida	700	2,888,338	1,137,273	3,377,814	83,246	88,091,981	12,375,205	240,513,622
Georgia	800	3,414,707	333,725	610,280	201,380	22,933,082	10,705,188	138,143,210
Hawaii	300	780,767	37,414	100,000	....	3,942,853	30,000	11,334,185
Idaho	104	487,135	57,000	70,000	1,026,013	4,533,273	1,267,851	14,751,317
Illinois	[illegible]	1,720,860	313,062	490,000	940,775	47,914,078	3,910,272	307,821,262
Indiana	[illegible]	2,094,070	204,021	108,674	32,887	19,088,707	11,371,184	92,850,464
Iowa	320	1,203,637	98,116	130,000	117,901	15,083,385	2,116,541	83,075,420
Kansas	295	1,340,483	75,262	225,334	13,790	11,365,537	1,670,879	77,640,617
Kentucky	309	1,080,106	108,493	108,024	1,350,287	13,062,778	2,795,433	79,025,086
Louisiana	240	850,105	194,030	110,774	56,886	18,763,123	5,571,420	93,191,717
Maine	250	382,390	97,500	80,000	4,966,480	4,023,846	1,135,837	32,857,186
Maryland	600	2,080,442	104,853	200,000	679	22,490,422	6,001,185	72,018,460
Massachusetts	810	2,124,201	304,652	856,480	....	33,221,671	4,984,700	187,286,108
Michigan	987	2,671,550	308,479	388,019	70,010	37,880,270	1,821,139	140,340,740
Minnesota	421	1,152,856	152,814	400,450	4,710,141	22,823,930	985,353	117,102,817
Mississippi	258	788,130	130,896	133,103	14,186	8,459,019	3,104,336	71,276,827
Missouri	415	1,177,747	210,384	280,244	54,850	23,284,813	2,081,256	184,881,523
Montana	109	480,381	41,501	65,000	5,386,023	5,380,472	675,120	18,616,846
Nebraska	207	940,120	112,156	107,386	440,637	6,673,582	1,080,628	50,616,864
Nevada	202	885,132	54,665	....	....	4,084,078	2,298,786	20,880,123
New Hampshire	442	1,338,375	87,043	246,000	1,501,320	6,201,385	140,863	17,845,037
New Jersey	704	2,714,420	282,611	413,190	....	38,384,560	1,382,380	108,486,633
New Mexico	246	1,039,486	57,025	187,630	1,472	5,177,238	1,085,628	37,032,807
New York	1,420	4,400,972	882,779	839,552	108,313	95,254,834	21,357,886	625,587,630
North Carolina	600	2,104,610	382,923	620,506	32,285	21,289,784	2,795,907	126,242,080
North Dakota	78	480,985	38,346	....	254,100	3,156,484	1,046,780	17,175,421
Ohio	1,862	4,883,563	560,910	701,817	434,952	52,856,153	13,341,888	210,280,334
Oklahoma	720	2,386,771	288,236	749,825	1,250,837	11,082,524	1,282,885	64,886,285
Oregon	780	2,334,032	157,780	477,511	31,580	13,180,885	1,186,750	73,213,783
Pennsylvania	1,096	2,990,220	580,220	823,380	348,126	59,880,134	8,853,500	[illegible]
Rhode Island	201	684,835	137,824	....	....	5,189,501	2,138,671	29,883,946
South Carolina	381	1,321,080	153,543	90,000	24,580	13,417,985	7,001,833	80,120,886
South Dakota	280	803,865	57,100	....	888,400	2,254,936	1,942,884	43,229,130
Tennessee	485	1,415,980	346,126	483,280	140,851	16,717,787	3,931,738	147,433,416
Texas	2,770	9,486,762	642,190	1,780,821	2,703,279	66,014,620	4,900,350	358,407,887
Utah	330	1,146,410	38,664	122,562	781,500	4,532,845	8,126,794	37,186,194
Vermont	107	488,725	113,630	88,884	2,986,231	1,903,356	577,855	18,558,570
Virginia	600	2,195,881	284,430	824,080	1,028,501	29,517,237	16,188,855	126,388,202
Washington	657	2,168,015	165,560	880,355	80,811	18,039,887	3,780,850	107,550,947
West Virginia	435	1,480,389	90,000	164,844	197,047	7,348,530	7,623,434	70,177,885
Wisconsin	483	1,453,864	150,001	379,574	880,951	20,031,857	9,334,570	128,048,635
Wyoming	43	64,934	37,282	....	2,918,800	1,801,936	494,480	21,788,083

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[1] Includes $14,962,180 in Grants for Construction of state extended care facilities.
[2] Includes 178 not identifiable by location.

[3] State distribution of expenditures for compensation and pension was revised in February 1980. Amounts shown in this table will differ from those included in "Expenditures by State FY 1981 Budget", published January 28, 1980.

Estimated Selected Expenditures By State—Fiscal Year 1979

State	Compensation and Pension							
	All Periods of Service							
	Living and Deceased Veterans						Living Veterans	
	Total		Service Connected		Non-Service Connected		Total	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount
World Total	4,769,510	$10,334,258,063	2,627,163	$6,771,849,060	2,142,366	$3,552,400,000	3,240,312	$7,706,087,115
Philippines	37,574	84,348,326	30,872	61,020,810	6,702	22,018,415-	14,199	32,657,785
Other Foreign Areas	20,357	58,495,335	9,467	35,473,373	10,890	23,022,562	8,485	26,621,900
Puerto Rico	44,835	157,902,458	22,816	101,063,824	22,009	55,838,645	32,419	133,003,263
Other U.S. Areas	1,136	2,709,675	783	2,007,985	353	701,690	799	1,833,145
Total U.S.	4,665,617	10,033,003,630	2,563,226	6,577,723,959	2,102,391	3,445,229,671	3,183,481	7,511,440,942
Alabama	94,838	257,051,081	48,498	130,080,365	46,340	88,870,696	61,040	164,411,467
Alaska	4,285	8,132,092	3,322	6,580,873	963	1,542,219	3,385	6,510,220
Arizona	57,944	144,601,793	37,043	110,169,321	20,901	34,432,472	42,215	113,234,177
Arkansas	70,260	170,253,160	32,104	108,229,541	38,156	72,033,619	47,380	138,501,084
California	465,052	869,652,841	237,630	663,773,338	167,422	205,879,503	282,307	618,062,430
Colorado	52,704	121,629,551	35,339	93,732,164	17,365	27,897,387	38,032	92,066,746
Connecticut	52,893	99,322,088	33,230	71,282,274	19,663	28,039,814	37,963	76,190,401
Delaware	11,036	22,009,088	6,414	14,911,960	4,622	7,097,130	7,499	15,996,436
District of Columbia	18,465	40,257,103	9,545	27,641,889	8,920	12,615,264	10,901	27,661,264
Florida	255,787	642,511,360	151,724	470,254,330	104,063	172,256,030	183,196	501,568,195
Georgia	124,220	292,477,748	63,343	181,519,145	60,877	110,958,603	81,413	211,187,088
Hawaii	12,124	27,682,332	9,186	22,867,905	2,938	4,814,427	8,951	20,463,567
Idaho	17,181	37,382,214	9,761	25,444,946	7,420	11,937,268	12,369	29,436,365
Illinois	164,587	295,551,636	81,787	170,680,470	82,800	124,871,166	106,352	211,344,230
Indiana	93,310	182,316,263	47,911	113,596,299	45,399	68,719,964	61,225	134,456,662
Iowa	52,058	106,330,387	25,773	63,986,205	26,285	42,343,162	34,607	81,124,067
Kansas	46,171	96,249,350	24,490	60,456,720	21,681	35,792,630	30,607	70,709,945
Kentucky	89,256	196,522,295	41,109	107,136,596	48,147	89,386,699	57,745	144,351,134
Louisiana	91,609	198,044,520	41,528	106,849,162	50,081	91,195,358	57,726	139,257,617
Maine	30,667	71,100,482	15,438	45,187,993	15,229	25,912,480	20,995	56,475,111
Maryland	75,184	157,477,877	44,188	109,743,804	31,006	47,734,073	49,870	111,020,862
Massachusetts	157,970	336,243,245	100,730	254,423,188	54,240	81,820,057	115,666	257,195,802
Michigan	159,078	315,702,541	91,668	217,808,362	67,410	97,996,179	108,952	242,066,939
Minnesota	82,534	166,172,916	45,940	102,935,293	36,586	63,237,523	58,032	128,428,034
Mississippi	69,625	161,683,472	30,080	84,232,910	39,485	77,360,562	44,063	117,082,930
Missouri	107,193	222,447,870	50,493	126,205,087	56,700	96,242,783	66,826	163,866,193
Montana	16,795	35,834,726	9,229	23,647,457	7,566	12,187,310	11,967	28,430,068
Nebraska	29,147	64,645,150	15,730	41,640,838	13,417	23,004,318	19,940	48,380,563
Nevada	15,908	32,976,249	10,302	24,747,353	5,606	8,228,896	11,902	25,729,064
New Hampshire	21,835	48,759,115	12,994	34,528,993	8,831	14,230,122	15,728	38,956,565
New Jersey	161,949	254,424,048	95,960	179,677,181	66,089	74,746,867	98,983	199,066,730
New Mexico	32,072	82,945,780	19,231	59,256,633	12,841	23,690,147	23,120	65,640,522
New York	354,639	713,186,476	201,009	477,780,202	153,630	235,386,274	248,140	551,704,875
North Carolina	131,383	298,447,487	63,060	177,983,963	68,323	120,463,524	85,520	210,435,138
North Dakota	10,913	22,375,859	6,190	13,727,718	4,723	8,648,141	7,760	17,488,620
Ohio	210,135	410,728,245	116,565	265,190,429	93,570	145,537,816	143,250	309,340,966
Oklahoma	83,686	208,146,747	43,750	131,789,471	39,936	76,357,276	56,777	161,576,418
Oregon	55,418	116,969,963	29,221	76,087,585	26,197	42,982,388	38,288	93,446,811
Pennsylvania	265,091	513,350,860	142,431	309,332,627	123,660	164,018,233	176,422	376,737,288
Rhode Island	25,635	53,600,210	15,361	39,297,317	10,274	14,302,893	18,072	41,803,273
South Carolina	67,893	144,086,088	31,317	80,842,074	36,576	63,246,014	41,991	96,080,625
South Dakota	15,856	36,363,003	7,305	20,474,967	8,551	15,888,036	10,994	26,732,135
Tennessee	108,252	233,108,957	48,442	125,784,834	59,810	107,324,063	69,650	168,436,859
Texas	309,295	746,810,336	173,342	501,791,852	135,953	245,018,324	212,027	560,712,283
Utah	18,876	39,670,956	12,253	29,309,245	6,623	10,361,711	13,534	30,862,932
Vermont	10,763	25,606,600	5,708	17,617,071	5,055	7,989,568	7,408	19,904,660
Virginia	115,965	270,880,370	65,548	187,121,799	50,417	83,758,571	78,080	195,414,957
Washington	81,960	187,721,484	51,919	138,675,532	30,041	49,045,952	58,706	144,582,088
West Virginia	52,681	113,630,513	24,572	63,920,392	28,109	49,609,121	34,350	84,870,812
Wisconsin	86,571	172,170,300	46,105	107,496,566	40,466	64,673,803	60,388	133,704,038
Wyoming	7,691	17,160,645	4,551	11,725,387	3,140	5,434,258	5,066	13,852,660

Estimated Selected Expenditures By State – Fiscal Year 1979

State	Compensation and Pension – Continued							
	All Periods of Service							
	Living Veterans				Deceased Veterans			
	Service Connected		Non-Service Connected		Total		Service Connected	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount
World Total	2,296,475	$8,555,346,380	973,837	$2,100,310,726	1,529,207	$2,618,600,948	380,088	$1,216,502,671
Philippines	11,536	29,616,740	2,663	12,142,481	23,375	51,988,549	19,336	41,114,616
Other Foreign Areas	6,022	14,772,876	3,423	11,840,084	10,962	29,873,975	3,445	13,780,487
Puerto Rico	30,274	83,876,882	12,146	39,628,601	12,416	24,790,306	2,541	7,987,142
Other U.S. Areas	636	1,860,734	132	372,411	378	826,530	147	487,251
Total U.S.	2,228,087	8,434,630,783	955,474	2,086,820,149	1,482,136	2,511,512,888	335,219	1,153,203,166
Alabama	40,348	93,892,876	21,186	50,518,881	35,282	63,138,804	8,150	28,787,480
Alaska	3,081	5,730,387	384	788,832	820	1,612,863	241	859,476
Arizona	32,881	81,447,856	10,134	21,777,121	15,729	31,377,616	4,982	18,722,265
Arkansas	28,870	89,458,181	20,886	48,132,703	22,892	39,671,316	5,434	16,770,480
California	202,515	466,548,125	78,752	161,416,214	122,745	231,580,402	35,115	137,127,213
Colorado	30,853	75,887,481	7,479	18,418,385	14,672	29,543,836	4,738	18,884,763
Connecticut	30,231	61,884,826	7,732	15,085,476	14,830	23,141,687	2,969	10,187,340
Delaware	5,881	12,198,818	1,808	3,787,418	3,637	6,012,858	723	2,712,946
District of Columbia	7,886	20,088,894	3,025	7,572,380	6,474	12,595,890	1,578	7,552,995
Florida	130,427	388,252,504	52,679	113,346,881	72,881	140,813,204	21,297	82,003,836
Georgia	81,933	161,884,552	29,480	70,083,146	42,837	81,310,050	11,410	40,434,583
Hawaii	7,881	18,013,831	1,850	2,449,626	3,173	7,218,675	1,285	4,853,874
Idaho	8,835	21,784,811	3,730	7,651,884	4,823	7,946,908	1,126	3,680,336
Illinois	72,285	161,738,583	24,087	68,605,853	58,235	84,297,400	9,442	28,941,887
Indiana	41,624	95,163,116	19,301	30,292,846	32,085	47,860,701	6,887	18,433,283
Iowa	22,415	54,118,634	12,282	27,006,033	17,381	25,216,300	3,358	9,878,171
Kansas	20,764	48,387,171	10,061	22,322,374	15,294	25,638,814	3,734	12,068,549
Kentucky	34,287	85,560,126	13,838	37,881,886	31,511	52,171,161	6,802	20,585,470
Louisiana	34,828	84,863,553	12,880	34,284,884	33,883	52,708,903	6,702	21,985,809
Maine	13,288	38,288,005	7,726	17,206,106	9,871	15,025,291	2,170	6,918,988
Maryland	38,870	85,805,037	11,890	25,415,835	25,294	46,457,616	6,088	24,138,787
Massachusetts	94,184	221,456,831	21,482	45,738,171	42,313	68,047,443	9,846	32,966,567
Michigan	83,830	181,108,782	25,922	61,880,157	50,124	73,123,802	8,836	26,687,580
Minnesota	41,129	98,334,498	16,903	40,033,841	24,472	37,744,882	4,920	14,880,980
Mississippi	24,455	66,214,349	20,200	50,888,590	24,862	44,520,533	5,806	18,019,581
Missouri	43,869	102,988,842	26,709	60,838,051	37,385	58,549,677	7,434	23,206,445
Montana	8,298	20,739,253	3,860	7,891,465	4,838	7,404,058	931	2,908,204
Nebraska	13,557	34,572,889	6,382	14,617,884	9,198	15,264,803	2,173	7,088,280
Nevada	9,256	20,683,825	2,648	5,036,133	3,808	7,247,191	1,046	4,053,429
New Hampshire	11,609	29,568,572	4,118	8,968,013	6,197	10,202,530	1,385	4,980,421
New Jersey	78,340	153,854,876	28,743	37,844,684	42,886	63,725,318	7,840	26,023,105
New Mexico	18,611	50,150,847	8,509	16,487,575	8,852	17,297,258	2,620	9,104,886
New York	182,786	417,885,308	65,344	136,129,567	106,899	161,371,801	18,213	60,114,894
North Carolina	53,822	143,411,810	33,898	75,823,328	45,863	80,012,349	10,438	34,572,153
North Dakota	5,577	12,615,775	2,173	5,472,845	3,163	4,887,230	613	1,711,943
Ohio	104,736	227,879,474	38,554	81,481,392	68,845	101,387,379	11,629	37,310,966
Oklahoma	38,958	109,828,740	19,819	51,747,678	25,909	46,578,329	6,792	21,980,731
Oregon	25,780	64,423,557	13,808	29,023,254	16,030	25,543,172	3,441	11,584,038
Pennsylvania	128,412	279,308,193	50,810	99,429,087	89,880	134,613,580	18,019	50,824,434
Rhode Island	13,819	33,722,122	4,253	8,071,161	7,583	11,796,837	1,542	5,566,195
South Carolina	25,393	60,110,077	16,598	38,770,548	25,902	47,198,463	5,924	20,731,907
South Dakota	6,427	17,625,332	4,477	10,806,803	4,852	7,880,888	878	2,849,635
Tennessee	40,889	100,206,705	29,581	68,229,153	38,602	64,673,138	8,353	25,578,228
Texas	146,383	404,443,956	65,644	156,288,387	67,288	186,088,063	26,950	97,347,046
Utah	10,919	34,780,398	2,615	5,692,536	5,342	9,008,024	1,334	4,528,847
Vermont	4,881	14,864,276	2,507	5,146,284	3,285	5,612,100	887	2,762,796
Virginia	54,898	144,748,174	23,261	50,086,783	37,876	75,465,413	10,740	42,373,825
Washington	45,340	113,717,718	13,645	30,864,970	23,175	43,138,796	6,679	26,857,814
West Virginia	20,642	53,047,883	13,717	31,923,029	18,222	28,657,601	3,930	10,881,500
Wisconsin	41,213	92,747,880	19,165	40,956,229	28,283	38,466,331	4,952	14,748,757
Wyoming	4,151	10,234,221	1,554	3,618,477	2,036	3,306,947	490	1,481,186

Estimated Selected Expenditures By State—Fiscal Year 1979

State	Compensation and Pension—Continued							
	All Periods of Service		Vietnam Era					
	Deceased Veterans		Living Veterans					
	Non-Service Connected		Total		Service Connected		Non-Service Connected	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount
World Total	1,168,510	$1,462,086,377	553,429	$1,358,214,831	537,219	$1,320,728,812	16,210	$37,486,019
Philippines	4,080	10,473,834	285	1,111,106	279	1,077,208	6	33,898
Other Foreign Areas	7,437	18,173,478	1,019	3,898,977	1,006	3,845,670	13	53,307
Puerto Rico	9,075	16,812,084	7,761	38,934,007	7,200	37,797,270	561	1,136,737
Other U.S. Areas	231	329,270	237	644,871	232	623,419	5	21,452
Total U.S.	1,146,917	1,258,309,522	542,026	1,313,535,010	527,941	1,277,272,065	14,085	36,252,505
Alabama	27,142	36,352,105	8,817	21,968,300	8,504	21,348,185	313	620,115
Alaska	579	753,387	1,398	2,388,047	1,382	2,337,010	16	51,037
Arizona	10,787	13,600,351	8,013	22,603,227	7,848	22,147,287	165	455,940
Arkansas	17,498	22,900,916	6,165	18,523,398	5,891	17,884,911	274	638,487
California	87,528	94,463,183	62,068	118,451,732	60,688	115,441,714	1,380	3,010,018
Colorado	9,806	11,479,842	8,550	23,287,695	8,428	22,978,221	122	309,474
Connecticut	11,031	12,944,330	5,495	12,437,033	5,307	11,989,901	188	447,132
Delaware	2,814	3,290,712	1,613	2,450,538	1,580	2,381,831	33	68,707
District of Columbia	3,095	6,042,904	2,172	5,094,265	2,125	4,941,027	47	153,238
Florida	51,304	58,900,260	34,462	94,835,368	33,723	92,940,489	739	1,894,879
Georgia	31,387	40,875,457	17,065	45,041,725	16,532	43,810,533	533	1,231,192
Hawaii	1,880	2,364,801	2,870	6,600,410	2,831	6,495,095	39	105,315
Idaho	3,037	4,289,574	2,098	4,638,394	2,065	4,554,812	33	83,582
Illinois	48,783	55,206,513	14,871	31,098,681	14,211	29,767,497	660	1,331,184
Indiana	30,068	39,427,418	9,013	24,530,841	8,670	23,639,617	343	891,224
Iowa	14,903	16,337,129	4,885	11,189,994	4,710	10,823,136	175	366,858
Kansas	11,630	13,470,285	4,866	10,850,887	4,719	10,527,536	147	323,351
Kentucky	24,039	31,985,631	7,279	18,903,918	7,014	18,287,370	265	616,548
Louisiana	27,181	28,801,294	8,086	19,827,053	7,771	19,145,438	315	681,615
Maine	7,001	8,706,383	3,486	9,505,318	3,350	9,150,775	136	354,543
Maryland	18,290	22,318,240	9,883	22,998,447	9,728	22,640,383	155	358,064
Massachusetts	32,767	38,080,895	10,375	39,188,554	9,942	38,123,837	433	1,064,717
Michigan	41,480	46,436,032	19,538	47,501,154	19,061	46,386,253	477	1,114,901
Minnesota	19,852	23,143,962	8,479	18,749,404	8,245	18,309,338	234	440,066
Mississippi	19,257	26,008,972	5,823	14,905,177	5,640	14,444,402	183	460,775
Missouri	29,931	35,344,232	9,287	22,706,270	8,979	21,865,986	308	840,284
Montana	3,897	4,496,054	2,313	5,151,869	2,248	4,990,894	65	160,975
Nebraska	7,085	8,106,324	3,084	7,572,776	2,999	7,355,085	85	217,691
Nevada	2,880	3,103,763	2,075	5,255,842	2,050	5,164,981	25	90,861
New Hampshire	4,612	5,242,106	3,691	9,173,052	3,630	8,853,379	61	319,673
New Jersey	35,336	37,702,213	13,597	30,176,108	13,309	29,572,957	288	603,151
New Mexico	6,332	8,192,872	6,198	13,080,119	6,042	12,717,261	156	362,858
New York	87,680	101,256,707	35,091	83,130,581	33,753	79,470,548	1,338	3,660,033
North Carolina	35,425	40,440,196	15,405	41,214,536	15,033	40,284,482	372	930,054
North Dakota	2,550	3,175,295	1,257	2,348,368	1,221	2,255,098	36	93,270
Ohio	59,018	64,070,424	22,041	51,313,555	21,356	49,610,254	685	1,703,301
Oklahoma	15,117	24,009,080	10,436	28,442,461	10,026	27,235,536	410	1,206,925
Oregon	12,560	12,959,164	7,394	16,967,811	7,294	16,443,815	100	523,996
Pennsylvania	73,860	84,680,141	22,957	51,360,845	22,302	49,776,490	655	1,584,355
Rhode Island	6,021	6,231,742	2,798	6,619,611	2,731	6,454,847	67	164,764
South Carolina	19,878	25,408,486	8,171	18,100,486	8,005	17,666,590	166	433,896
South Dakota	4,574	5,001,233	1,806	4,724,139	1,718	4,483,217	88	240,922
Tennessee	30,249	30,094,910	9,064	24,679,548	8,814	23,825,927	250	853,621
Texas	70,359	68,751,617	46,013	120,253,580	45,169	118,120,002	844	2,133,578
Utah	4,998	6,478,177	2,843	5,740,438	2,801	5,602,037	42	138,401
Vermont	2,548	2,849,304	1,169	3,481,916	1,102	3,307,749	67	174,167
Virginia	27,135	33,681,700	18,200	46,881,781	17,852	46,032,497	348	849,284
Washington	16,498	19,180,983	14,549	34,902,141	14,259	34,206,143	290	695,998
West Virginia	14,382	17,778,093	4,467	11,197,970	4,341	10,774,465	126	423,505
Wisconsin	21,251	23,717,574	9,811	20,616,007	9,470	19,735,199	341	880,808
Wyoming	1,586	1,815,781	1,265	2,939,586	1,231	2,838,149	34	101,437

Estimated Selected Expenditures By State—Fiscal Year 1979

State	Compensation and Pension—Continued							
	Vietnam Era						Korean Conflict	
	Deceased Veterans						Living Veterans	
	Total		Service Connected		Non-Service Connected		Total	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount
World Total	92,907	$288,084,014	64,076	$247,353,484	28,801	$41,311,630	317,372	$853,467,071
Philippines	296	1,170,080	251	1,024,554	45	145,525	136	575,776
Other Foreign Areas	1,472	8,511,886	1,269	8,183,300	203	328,586	747	2,307,123
Puerto Rico	875	2,361,112	621	1,925,402	254	435,710	8,360	32,874,286
Other U.S. Areas	58	187,584	47	173,703	11	13,881	143	337,510
Total U.S.	90,306	276,333,794	61,938	236,046,400	28,368	40,287,388	307,077	817,273,274
Alabama	2,430	7,921,704	1,714	6,887,839	716	1,033,925	5,080	15,801,711
Alaska	168	508,094	120	442,892	48	65,202	384	822,135
Arizona	1,530	4,911,361	1,064	4,333,336	470	607,005	4,175	13,309,015
Arkansas	1,285	3,727,904	985	3,157,864	300	570,040	3,980	13,461,785
California	8,781	32,598,841	6,821	28,647,465	2,960	3,951,376	30,037	75,772,487
Colorado	1,679	5,958,356	1,272	5,372,309	407	586,047	3,840	10,257,880
Connecticut	551	1,650,440	399	1,361,728	152	288,712	3,601	7,895,747
Delaware	273	886,751	183	775,532	90	111,220	732	1,885,616
District of Columbia	303	997,272	207	861,726	96	135,546	1,437	4,334,903
Florida	5,388	18,688,274	4,134	16,938,832	1,254	1,750,402	16,574	56,530,807
Georgia	3,813	12,469,947	2,814	11,102,311	999	1,366,636	7,974	23,741,043
Hawaii	495	1,896,074	404	1,765,341	91	130,733	1,322	3,460,108
Idaho	467	1,143,888	282	957,866	185	186,223	1,088	2,031,078
Illinois	2,557	8,626,531	1,463	6,944,157	1,099	1,682,374	8,747	21,884,962
Indiana	1,636	4,347,730	989	3,441,460	647	906,271	5,804	14,131,840
Iowa	663	1,783,171	417	1,426,317	246	357,854	2,073	7,757,770
Kansas	969	2,571,671	640	2,082,475	329	489,196	2,884	7,169,071
Kentucky	1,739	4,976,390	1,208	4,221,675	531	754,715	5,463	14,867,862
Louisiana	2,031	5,637,614	1,310	4,612,339	712	1,025,275	5,629	14,424,266
Maine	589	1,760,380	400	1,507,507	189	252,873	2,140	8,370,687
Maryland	1,795	6,131,433	1,304	5,449,219	491	682,204	5,273	12,861,085
Massachusetts	1,565	4,662,137	1,093	3,863,262	472	798,885	14,220	33,961,724
Michigan	2,564	6,552,090	1,405	4,801,053	1,159	1,751,037	10,500	26,985,045
Minnesota	865	2,435,431	566	1,935,633	300	499,798	5,181	12,171,862
Mississippi	1,332	4,062,053	955	3,508,466	377	552,587	3,825	11,019,780
Missouri	1,913	5,279,302	1,195	4,258,580	718	1,020,723	6,398	16,739,883
Montana	335	802,095	199	611,201	136	190,894	1,031	2,857,006
Nebraska	544	1,582,159	351	1,341,639	193	241,530	1,994	5,028,831
Nevada	436	1,412,981	303	1,235,948	133	176,012	1,196	2,164,366
New Hampshire	307	1,078,773	248	938,169	59	138,604	1,577	4,240,704
New Jersey	1,553	5,080,539	1,004	4,230,680	570	849,850	10,307	21,527,084
New Mexico	887	2,577,674	649	2,100,057	238	477,617	2,300	7,628,082
New York	3,435	9,430,403	2,083	7,397,721	1,352	2,032,682	24,316	59,882,025
North Carolina	3,568	11,451,403	2,698	10,081,080	880	1,370,403	7,005	23,066,613
North Dakota	160	423,880	102	343,131	58	80,868	630	1,657,120
Ohio	3,281	8,838,336	1,961	6,894,080	1,330	1,944,256	13,861	33,311,289
Oklahoma	1,884	5,796,013	1,336	4,902,008	549	894,105	5,100	16,760,831
Oregon	970	2,709,556	590	2,188,130	380	521,419	3,196	8,743,782
Pennsylvania	3,290	9,166,876	2,036	7,309,476	1,254	1,857,400	16,508	40,686,843
Rhode Island	306	1,082,888	208	946,847	98	136,161	1,085	4,050,802
South Carolina	2,172	7,133,765	1,576	6,285,582	596	838,183	3,707	10,253,086
South Dakota	253	642,968	153	509,736	100	133,232	1,076	3,100,482
Tennessee	2,318	6,776,666	1,601	5,777,820	717	998,860	5,830	16,381,760
Texas	7,910	26,196,452	5,829	23,240,237	2,081	2,955,215	18,226	50,794,076
Utah	431	1,271,118	275	1,065,477	156	205,641	1,294	3,887,851
Vermont	169	535,985	123	474,087	46	61,898	702	2,408,380
Virginia	3,384	12,608,941	2,630	11,550,001	754	1,058,940	7,896	22,881,084
Washington	2,086	6,808,048	1,510	6,095,150	576	703,898	5,804	16,684,420
West Virginia	892	2,481,553	613	2,038,039	280	443,514	3,720	10,330,019
Wisconsin	879	2,062,115	587	1,498,113	292	564,002	6,046	13,867,331
Wyoming	190	526,094	114	425,247	74	100,847	608	1,352,070

Estimated Selected Expenditures By State—Fiscal Year 1979

State	Compensation and Pension—Continued							
	Korean Conflict							
	Living Veterans				Deceased Veterans			
	Service Connected		Non-Service Connected		Total		Service Connected	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount
World Total	237,100	$880,040,520	80,200	$102,521,451	138,380	287,488,284	39,237	$121,289,288
Philippines	110	520,700	20	48,990	185	683,270	122	512,880
Other Foreign Areas	684	2,021,381	63	285,802	777	1,080,980	363	1,284,087
Puerto Rico	4,060	23,085,512	3,270	9,088,774	3,251	5,271,865	668	2,288,096
Other U.S. Areas	130	277,320	20	60,170	67	116,143	10	43,840
Total U.S.	231,213	854,212,085	76,704	102,088,880	138,080	283,488,100	37,066	120,086,427
Alabama	4,301	11,083,992	1,965	3,907,710	3,300	6,340,630	1,033	3,048,882
Alaska	360	730,740	34	91,385	127	227,094	10	60,890
Arizona	3,360	11,483,042	815	1,068,773	1,502	3,472,173	533	2,002,401
Arkansas	2,549	10,210,463	1,384	3,143,302	1,677	2,863,210	585	1,601,012
California	23,686	81,070,275	8,381	13,084,212	12,570	28,302,617	4,380	13,207,884
Colorado	3,262	8,011,557	670	1,348,443	1,536	3,288,836	462	1,844,537
Connecticut	2,974	8,421,860	527	1,473,787	1,472	2,881,271	366	814,273
Delaware	501	1,488,860	141	348,886	350	714,382	81	338,738
District of Columbia	1,080	3,288,521	357	1,048,382	645	1,012,135	253	1,238,877
Florida	12,400	48,540,102	6,094	9,885,205	8,526	15,626,161	2,532	10,437,719
Georgia	5,043	16,420,085	2,631	7,212,146	3,631	7,762,010	1,280	4,079,785
Hawaii	1,183	3,175,532	120	274,888	480	1,023,626	210	840,826
Idaho	875	2,487,851	191	843,127	480	788,751	97	383,884
Illinois	7,187	15,617,823	3,580	5,987,169	5,880	8,884,470	1,010	2,574,328
Indiana	4,943	10,948,016	1,661	3,885,824	2,910	4,710,437	697	1,578,377
Iowa	2,357	6,071,645	716	1,880,133	1,438	2,308,544	324	605,880
Kansas	2,016	5,844,085	589	1,348,388	1,273	3,061,380	302	1,128,380
Kentucky	3,382	8,387,070	2,101	5,080,022	2,580	4,844,841	789	1,812,316
Louisiana	3,884	10,288,123	1,735	4,085,138	2,704	6,288,480	649	2,420,070
Maine	1,483	4,088,207	467	1,770,780	685	1,610,085	285	691,115
Maryland	6,298	10,401,135	1,635	2,510,880	2,583	6,588,680	714	2,071,816
Massachusetts	12,650	28,421,710	2,187	5,520,088	3,640	6,857,152	689	3,088,284
Michigan	6,281	21,687,677	2,338	5,338,888	5,840	8,288,131	861	2,380,868
Minnesota	4,340	10,173,285	632	1,988,587	2,208	3,713,285	680	1,240,282
Mississippi	2,420	7,884,488	1,485	3,388,322	1,848	3,713,840	670	1,088,749
Missouri	4,573	12,288,862	1,617	4,388,081	3,128	6,843,045	896	2,370,484
Montana	611	2,171,070	488	488,880	488	888,888	68	284,887
Nebraska	1,087	4,032,132	467	1,034,286	910	1,601,380	210	560,086
Nevada	867	2,721,702	289	642,894	461	686,030	110	430,860
New Hampshire	1,168	3,177,250	617	1,072,440	584	1,167,128	160	503,510
New Jersey	8,407	17,867,677	1,880	3,888,327	4,030	7,088,384	783	3,044,637
New Mexico	1,701	6,091,683	588	1,044,342	872	2,576,125	203	1,077,480
New York	17,860	43,742,811	6,360	15,840,214	9,271	18,263,367	1,731	6,288,480
North Carolina	6,407	16,067,880	2,638	6,149,533	4,080	7,343,328	1,107	3,451,488
North Dakota	582	1,341,288	157	310,721	381	573,881	80	185,482
Ohio	10,515	25,048,844	3,488	8,381,286	6,083	16,233,380	1,260	3,148,271
Oklahoma	3,690	12,740,670	1,401	4,010,865	3,120	6,163,207	786	2,328,010
Oregon	2,310	6,048,443	680	2,086,320	1,380	2,414,387	348	1,128,224
Pennsylvania	12,601	30,740,484	6,057	9,288,130	7,080	13,231,103	1,680	4,888,862
Rhode Island	1,280	3,330,285	325	711,507	604	1,186,882	165	534,884
South Carolina	2,527	7,241,135	1,254	3,012,680	2,011	4,763,880	721	2,226,652
South Dakota	789	2,257,102	387	912,384	480	880,530	88	288,880
Tennessee	3,680	10,884,527	2,350	6,387,203	3,161	6,477,880	862	2,488,207
Texas	14,024	48,211,114	4,350	10,473,702	8,422	15,753,416	2,048	11,294,242
Utah	1,110	3,176,047	189	391,084	613	1,082,570	130	438,840
Vermont	532	1,047,147	286	558,142	277	513,350	77	228,170
Virginia	5,717	17,683,385	2,136	5,017,088	3,727	6,571,120	1,360	5,346,180
Washington	4,850	14,886,042	1,081	2,588,776	3,098	5,438,638	687	3,278,288
West Virginia	2,104	6,530,084	1,534	3,798,535	1,880	2,880,201	535	1,082,862
Wisconsin	4,570	10,712,373	1,480	3,174,880	2,370	3,072,846	687	1,427,484
Wyoming	384	1,104,014	112	267,480	215	283,284	46	143,480

TABLE [illegible]—Continued

Estimated Selected Expenditures By State—Fiscal Year 1979

State	Compensation and Pension–Continued							
	Korean Conflict		World War II					
	Deceased Veterans		Living Veterans					
	Non-Service Connected		Total		Service Connected		Non-Service Connected	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount
World Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	$2,830,936,294	681,483	$1,440,778,006
Philippines	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	16,830,524	1,094	7,252,824
Other Foreign Areas	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	5,713,838	1,458	3,074,317
Puerto Rico	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	19,041,522	6,787	20,896,873
Other U.S. Areas	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	350,830	86	274,083
Total U.S.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	2,788,981,479	671,265	1,409,280,108
Alabama	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	47,488,907	15,671	34,540,735
Alaska	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1,943,500	227	543,037
Arizona	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	43,775,725	7,118	16,136,125
Arkansas	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	48,130,201	16,141	33,012,078
California	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	214,913,351	56,378	104,898,136
Colorado	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	30,943,888	4,789	9,995,224
Connecticut	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	34,702,915	9,111	9,801,315
Delaware	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	5,844,886	1,339	2,883,350
District of Columbia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	8,208,984	2,238	5,487,011
Florida	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	183,053,304	36,182	75,753,164
Georgia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	88,082,121	22,348	58,861,876
Hawaii	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	5,883,161	638	1,438,624
Idaho	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	11,808,426	2,488	4,718,037
Illinois	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	80,967,548	23,294	46,289,707
Indiana	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	48,063,833	12,649	24,707,842
Iowa	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	38,473,057	7,441	15,338,336
Kansas	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	25,206,803	6,361	13,125,519
Kentucky	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	47,307,873	17,280	40,798,739
Louisiana	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	44,256,840	17,384	30,063,445
Maine	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	19,525,169	5,470	11,541,586
Maryland	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	40,188,970	8,488	18,021,381
Massachusetts	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	129,887,028	14,087	29,440,579
Michigan	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	102,580,382	17,030	33,382,472
Minnesota	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	49,587,883	10,683	22,879,465
Mississippi	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	36,037,382	16,734	37,709,744
Missouri	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	84,533,631	18,272	38,854,384
Montana	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	10,738,882	2,831	5,112,880
Nebraska	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	18,142,648	4,134	8,173,546
Nevada	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9,428,850	2,014	3,808,487
New Hampshire	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	13,840,254	2,844	5,983,484
New Jersey	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90,553,601	13,827	24,550,532
New Mexico	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	24,703,237	4,841	10,847,344
New York	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	240,488,928	46,534	88,771,016
North Carolina	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	88,437,837	24,943	54,117,552
North Dakota	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	6,703,581	1,438	3,337,721
Ohio	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	126,862,193	28,290	54,587,482
Oklahoma	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	53,964,934	14,116	34,212,829
Oregon	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	31,387,146	9,037	18,384,625
Pennsylvania	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	188,032,837	35,281	68,075,886
Rhode Island	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	20,171,101	2,837	5,232,860
South Carolina	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	28,828,985	12,935	26,871,059
South Dakota	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	8,858,543	2,764	6,136,110
Tennessee	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	51,934,283	22,283	48,743,359
Texas	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	188,411,350	48,835	110,867,288
Utah	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	12,561,622	1,884	3,886,244
Vermont	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	7,706,494	1,781	3,294,884
Virginia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	88,356,123	17,161	36,753,357
Washington	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	48,151,476	8,578	18,336,156
West Virginia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	29,279,842	9,687	21,828,586
Wisconsin	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	48,219,367	11,781	23,594,887
Wyoming	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	4,748,882	1,013	2,285,544

Estimated Selected Expenditures By State—Fiscal Year 1979

State	Compensation and Pension—Continued							
	World War II						World War I	
	Deceased Veterans						Living Veterans	
	Total		Service Connected		Non-Service Connected		Total	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount
World Total	708,458	$1,205,324,415	176,742	$522,237,830	531,716	$683,086,585	230,846	$648,979,683
Philippines	19,661	39,481,401	18,127	36,119,781	1,534	3,361,620	747	4,848,486
Other Foreign Areas	2,978	5,661,881	742	2,522,862	2,236	3,139,019	2,011	8,304,102
Puerto Rico	3,492	8,028,893	616	2,087,915	2,876	5,940,978	1,518	8,214,729
Other U.S. Areas	141	272,710	38	106,867	103	165,843	8	28,003
Total U.S.	682,186	1,151,871,445	157,219	481,400,405	524,967	670,471,040	226,562	566,506,383
Alabama	16,157	27,475,292	3,423	9,665,453	12,734	17,809,839	4,151	12,982,087
Alaska	305	503,157	55	176,211	250	326,946	42	122,140
Arizona	6,719	12,080,904	1,942	6,609,840	4,777	5,471,064	2,896	6,753,735
Arkansas	9,834	16,913,115	2,576	7,063,476	7,258	9,849,639	4,396	14,394,005
California	52,500	94,726,513	14,210	49,839,202	38,290	44,887,311	19,580	43,170,466
Colorado	5,054	10,106,028	1,021	5,157,023	4,033	4,949,005	2,881	7,136,188
Connecticut	7,635	11,649,672	1,053	5,083,332	6,582	6,566,340	2,332	4,822,531
Delaware	1,790	2,936,636	311	1,057,187	1,479	1,879,449	346	895,779
District of Columbia	2,632	5,897,669	665	3,164,652	1,967	2,733,017	509	1,398,821
Florida	31,494	59,456,061	9,071	31,635,304	22,423	27,820,757	14,128	34,101,465
Georgia	19,395	34,552,339	4,584	14,477,481	14,811	20,074,858	4,214	12,741,986
Hawaii	1,145	2,179,653	366	1,152,889	779	1,026,764	291	691,463
Idaho	1,986	3,333,886	511	1,489,424	1,475	1,844,462	1,176	2,843,242
Illinois	28,009	43,412,487	5,214	14,769,912	22,795	28,642,575	8,909	18,822,501
Indiana	14,238	22,305,492	3,007	8,309,822	11,231	13,995,670	5,969	12,287,301
Iowa	7,332	11,477,440	1,900	5,067,995	5,432	6,409,445	4,437	11,218,513
Kansas	6,434	10,786,754	1,850	5,100,574	4,584	5,686,180	3,353	8,696,588
Kentucky	14,695	24,135,555	3,361	8,738,804	11,334	15,396,751	4,630	12,964,170
Louisiana	16,447	28,327,024	2,982	8,897,260	13,465	19,429,764	3,839	11,969,819
Maine	4,332	7,152,924	1,086	3,018,293	3,246	4,134,631	1,629	4,108,486
Maryland	11,692	20,668,826	2,517	9,038,302	9,175	11,630,524	2,675	6,010,247
Massachusetts	20,386	35,077,311	5,279	16,955,827	15,107	18,121,484	6,239	14,709,635
Michigan	24,015	38,100,807	4,781	13,750,289	19,234	24,350,518	7,065	14,212,047
Minnesota	10,371	16,957,733	2,580	7,154,616	7,791	9,803,117	6,402	18,649,591
Mississippi	11,160	19,475,330	2,389	6,750,829	8,771	12,724,501	3,435	11,229,382
Missouri	16,097	25,854,048	3,662	10,116,643	12,435	15,737,405	7,245	19,966,563
Montana	2,124	3,373,842	438	1,239,735	1,686	2,134,107	1,050	2,555,847
Nebraska	3,865	6,554,999	1,124	3,251,610	2,741	3,303,389	2,034	5,356,673
Nevada	1,690	2,903,207	383	1,342,386	1,307	1,560,821	490	1,088,044
New Hampshire	2,828	4,666,710	645	2,126,904	2,183	2,539,806	939	2,163,360
New Jersey	21,547	34,318,940	4,339	13,539,177	17,208	20,779,763	5,466	9,964,088
New Mexico	3,919	7,311,107	1,140	3,505,804	2,779	3,805,303	1,384	4,042,282
New York	55,050	89,594,369	11,162	34,804,219	43,888	54,790,150	14,174	29,708,509
North Carolina	21,626	35,964,892	4,435	12,760,702	17,191	23,204,190	5,882	15,694,218
North Dakota	1,342	2,107,154	307	774,513	1,035	1,332,641	682	2,165,917
Ohio	32,826	52,124,201	6,243	18,133,820	26,583	33,990,381	9,672	21,076,312
Oklahoma	10,617	18,431,977	3,083	8,602,910	7,534	9,829,067	4,353	14,494,181
Oregon	6,560	10,812,406	1,616	4,879,931	4,944	5,932,475	4,030	8,673,124
Pennsylvania	47,863	75,481,010	9,324	26,791,084	38,539	48,689,926	11,736	24,489,269
Rhode Island	3,501	5,835,491	827	2,719,114	2,674	3,116,377	1,188	2,517,027
South Carolina	11,960	20,163,402	2,198	6,598,036	9,762	13,565,366	2,520	7,179,682
South Dakota	1,865	2,999,054	430	1,150,212	1,435	1,848,842	1,423	4,149,699
Tennessee	17,824	29,407,856	3,827	10,312,439	13,997	19,095,417	5,307	15,190,310
Texas	43,083	78,348,578	11,615	36,707,603	31,468	41,640,975	13,292	39,445,943
Utah	2,250	3,842,456	620	1,831,860	1,630	2,010,596	994	2,170,140
Vermont	1,521	2,611,426	410	1,278,517	1,111	1,332,909	583	1,482,794
Virginia	16,473	29,673,234	3,986	13,431,516	12,487	16,241,718	4,170	10,872,580
Washington	8,748	15,742,414	2,554	8,357,780	6,194	7,384,634	4,318	10,449,712
West Virginia	9,208	14,682,586	2,111	5,379,713	7,097	9,302,873	2,630	6,923,854
Wisconsin	11,295	17,638,779	2,634	7,032,436	8,661	10,606,343	6,413	15,762,383
Wyoming	778	1,278,201	185	539,837	593	738,364	473	1,249,810

Estimated Selected Expenditures By State—Fiscal Year 1979

State	Compensation and Pension									
	World War I									
	Living Veterans						Deceased Veterans			
	Service Connected		Emergency Officer Retirement Pay		Non-Service Connected		Total		Service Connected	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount
World Total	34,220	$108,944,703	202	$1,241,340	198,424	478,193,850	524,466	$630,217,284	31,284	$121,219,921
Philippines	12	83,340	....	....	735	4,763,118	2,168	5,906,750	129	539,515
Other Foreign Areas	134	674,114	....	....	1,877	8,420,988	4,688	13,063,397	283	1,241,879
Puerto Rico	38	390,821	....	....	1,470	7,824,808	5,305	7,728,385	105	474,714
Other U.S. Areas	2	11,303	....	....	6	16,700	62	72,378	2	6,831
Total U.S.	34,033	108,386,017	202	1,241,340	192,327	457,050,030	512,184	612,446,346	30,785	118,958,982
Alabama	532	1,609,710	3	18,073	3,016	11,353,975	11,865	16,407,546	644	2,487,823
Alaska	5	18,775	....	....	37	103,373	185	210,147	4	18,385
Arizona	686	2,454,886	5	27,858	2,031	4,371,831	4,690	6,663,974	599	2,302,044
Arkansas	512	2,046,124	3	17,808	3,823	12,322,875	9,310	13,436,306	687	2,578,800
California	3,978	12,774,477	32	280,733	15,670	30,393,298	38,960	44,234,797	3,102	12,125,586
Colorado	590	2,345,081	4	20,280	1,987	4,751,807	4,800	6,517,281	564	2,130,310
Connecticut	531	1,852,048	1	16,776	1,808	3,353,710	8,341	5,710,088	373	1,432,740
Delaware	47	112,050	2	8,675	304	685,045	985	1,028,335	28	148,201
District of Columbia	125	304,895	5	30,918	379	953,008	1,447	2,014,100	127	851,780
Florida	2,488	8,303,890	20	125,290	11,622	25,882,276	24,526	29,068,307	1,651	6,618,086
Georgia	545	1,847,118	7	42,724	3,601	10,052,143	13,538	18,956,824	817	3,582,700
Hawaii	17	60,404	....	....	244	631,048	748	965,890	22	83,175
Idaho	128	439,113	....	....	1,048	2,404,129	1,774	2,074,841	97	362,562
Illinois	1,173	2,780,907	7	38,752	7,739	15,085,842	28,849	21,288,601	838	3,268,015
Indiana	821	2,113,498	2	13,832	4,746	10,100,901	12,185	13,508,785	708	2,732,027
Iowa	488	1,632,132	1	5,217	3,938	8,670,164	7,462	8,306,186	384	1,482,671
Kansas	386	1,194,094	....	1,006	2,857	7,601,488	5,966	7,201,272	325	1,277,888
Kentucky	747	2,089,725	3	17,228	3,880	10,857,210	11,283	15,108,888	728	2,780,447
Louisiana	334	1,302,058	1	5,480	3,494	10,061,301	11,509	15,888,818	632	2,411,875
Maine	184	574,011	2	8,914	1,443	3,523,060	3,601	4,094,708	181	704,386
Maryland	483	1,483,062	5	26,647	2,128	4,510,538	7,637	8,077,481	458	1,832,006
Massachusetts	1,488	5,071,624	8	38,375	4,708	8,881,638	15,400	17,811,710	1,237	4,828,807
Michigan	985	2,801,938	....	2,782	6,050	11,707,957	17,236	16,083,120	732	2,780,521
Minnesota	1,117	3,890,952	5	27,489	5,250	14,882,110	10,280	12,880,142	741	2,802,383
Mississippi	581	1,952,980	1	5,840	2,893	9,270,473	9,555	14,441,177	853	3,236,496
Missouri	987	2,705,742	9	52,053	6,388	16,808,788	14,816	18,037,158	825	3,141,841
Montana	200	630,930	....	....	850	1,827,909	1,730	1,944,830	108	397,356
Nebraska	286	943,404	1	5,400	1,757	4,408,700	3,519	4,373,104	311	787,536
Nevada	83	287,441	....	....	397	880,603	1,101	1,211,168	66	280,858
New Hampshire	139	484,634	2	8,625	787	1,880,100	2,171	2,476,907	149	583,567
New Jersey	764	1,943,611	2	10,888	4,710	7,995,081	14,464	13,367,889	583	2,200,837
New Mexico	272	1,082,985	2	11,435	1,130	2,937,881	2,748	3,887,378	270	1,058,820
New York	2,074	6,029,404	9	61,995	12,091	23,887,290	35,730	39,012,364	1,867	6,907,311
North Carolina	814	2,098,804	3	18,329	4,885	13,790,388	14,768	18,169,117	867	2,894,534
North Dakota	124	446,117	....	....	588	1,720,880	1,190	1,538,247	59	222,135
Ohio	1,572	4,177,082	7	38,010	8,083	18,866,204	22,842	25,126,230	1,341	4,813,128
Oklahoma	581	2,108,807	2	12,485	3,790	12,295,079	10,081	14,153,481	588	2,344,886
Oregon	480	1,622,140	2	10,280	3,537	8,040,775	6,417	7,441,087	418	1,588,389
Pennsylvania	1,778	5,807,863	9	58,778	9,951	18,434,828	28,630	30,080,370	1,388	5,410,634
Rhode Island	168	555,806	1	5,480	1,019	1,858,841	2,836	2,677,884	111	434,856
South Carolina	277	708,849	4	28,113	2,248	6,440,720	8,181	11,081,038	462	1,776,233
South Dakota	165	537,611	....	....	1,257	3,012,088	2,222	2,808,985	108	412,287
Tennessee	618	1,963,980	5	28,485	4,684	13,186,860	13,688	18,429,087	706	3,086,782
Texas	1,528	5,888,111	12	70,324	11,741	33,517,508	32,738	43,725,851	2,064	8,080,233
Utah	156	423,770	....	....	838	1,754,370	1,818	2,012,748	116	433,706
Vermont	106	376,636	....	....	477	1,108,158	1,233	1,478,574	93	370,273
Virginia	544	1,797,587	8	48,338	3,627	9,025,754	11,812	14,549,410	613	2,386,860
Washington	636	2,303,101	4	22,790	3,675	8,223,821	8,201	9,476,858	525	2,034,428
West Virginia	300	850,730	1	6,002	2,319	6,067,122	6,116	7,400,848	272	1,035,180
Wisconsin	852	2,461,481	4	23,309	5,557	13,277,613	10,833	12,273,444	680	2,536,885
Wyoming	78	261,080	1	5,217	394	982,403	760	894,856	48	176,181

Estimated Selected Expenditures By State—Fiscal Year 1979

State	Compensation and Pension									
	World War I		Regular Establishment							
	Deceased Veterans		Living Veterans							
	Non-Service Connected		Total		Service Connected		Reserve Officers		Special Acts	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount
World Total	483,171	$817,887,313	340,232	$831,853,896	340,196	$831,878,866	1	$7,304	23	$5,736
Philippines	2,037	5,307,244	385	1,965,436	385	1,965,436	......	......	......	......
Other Foreign Areas	4,405	11,821,518	833	2,318,062	833	2,318,062	......	......	......	......
Puerto Rico	5,280	7,253,671	2,939	12,830,467	2,939	12,830,467	......	......	......	......
Other U.S. Areas	80	95,347	181	288,748	181	288,748	......	......	......	......
Total U.S.	481,410	483,400,363	335,994	814,470,360	335,940	814,457,263	1	7,304	23	5,736
Alabama	11,211	13,830,723	4,581	11,883,100	4,581	11,883,100	......	......	......	......
Alaska	181	181,762	428	798,763	428	798,763	......	......	......	......
Arizona	4,300	4,381,930	4,089	11,541,089	4,088	11,540,936	......	......	1	153
Arkansas	8,632	10,856,487	2,994	11,052,719	2,993	11,052,566	......	......	1	153
California	35,897	32,108,211	34,213	61,433,051	34,211	61,432,746	......	......	2	305
Colorado	4,236	4,398,961	4,185	10,459,396	4,185	10,459,396	......	......	......	......
Connecticut	4,988	4,287,938	2,988	6,400,438	2,988	6,400,438	......	......	......	......
Delaware	947	878,044	857	1,594,979	857	1,594,979	......	......	......	......
District of Columbia	1,339	1,482,300	1,052	3,239,098	1,051	3,238,969	......	......	1	137
Florida	28,835	23,048,611	18,986	48,208,558	18,984	48,208,278	......	......	2	280
Georgia	12,621	15,353,044	6,510	18,872,511	6,509	18,872,358	......	......	1	153
Hawaii	724	832,724	1,240	2,599,609	1,240	2,599,609	......	......	......	......
Idaho	1,677	1,712,279	1,021	2,494,319	1,021	2,494,319	......	......	......	......
Illinois	18,810	18,032,486	5,847	12,560,853	5,847	12,560,853	......	......	......	......
Indiana	11,477	10,898,768	3,891	9,710,726	3,889	9,710,420	......	......	2	306
Iowa	7,078	8,842,725	1,851	5,112,847	1,851	5,112,847	......	......	......	......
Kansas	5,639	5,933,404	2,104	5,614,768	2,103	5,613,068	......	......	1	1,700
Kentucky	10,567	12,336,381	3,238	9,461,883	3,233	9,460,764	......	......	5	1,119
Louisiana	10,877	13,274,843	3,718	9,813,708	3,718	9,813,708	......	......	......	......
Maine	3,430	3,390,312	1,533	4,380,980	1,533	4,380,980	......	......	......	......
Maryland	7,370	7,044,765	4,701	10,814,840	4,701	10,814,840	......	......	......	......
Massachusetts	14,183	12,582,813	8,724	19,895,080	8,724	19,895,080	......	......	......	......
Michigan	18,504	13,922,908	7,232	17,988,795	7,232	17,988,795	......	......	......	......
Minnesota	8,839	10,087,878	3,739	8,276,516	3,739	8,276,516	......	......	......	......
Mississippi	8,702	11,295,882	2,390	7,119,351	2,389	7,119,198	......	......	1	153
Missouri	14,081	14,898,518	4,157	11,485,838	4,157	11,485,838	......	......	......	......
Montana	1,632	1,947,483	885	2,357,303	885	2,357,303	......	......	......	......
Nebraska	3,308	3,576,980	1,422	4,102,872	1,421	4,102,719	......	......	1	153
Nevada	1,038	980,316	1,210	3,081,151	1,210	3,081,151	......	......	......	......
New Hampshire	2,022	1,862,380	1,380	3,316,421	1,380	3,316,421	......	......	......	......
New Jersey	13,801	11,157,852	6,876	13,910,214	6,876	13,910,214	......	......	......	......
New Mexico	2,479	2,840,750	1,039	3,534,380	1,039	3,534,380	......	......	......	......
New York	38,082	32,085,033	18,756	38,889,017	18,754	38,888,712	......	......	2	305
North Carolina	14,081	18,574,583	6,103	17,887,981	6,102	17,887,579	......	......	1	382
North Dakota	1,137	1,317,112	633	1,270,062	633	1,270,062	......	......	......	......
Ohio	31,001	29,312,104	8,899	22,332,911	8,898	22,332,758	......	......	1	153
Oklahoma	9,403	11,909,906	4,003	13,684,316	4,003	13,684,316	......	......	......	......
Oregon	5,990	5,845,030	3,082	8,311,805	3,082	8,311,805	......	......	......	......
Pennsylvania	27,242	34,669,736	11,134	27,690,877	11,134	27,690,877	......	......	......	......
Rhode Island	2,734	2,243,160	1,290	3,253,631	1,290	3,253,631	......	......	......	......
South Carolina	7,739	6,335,808	2,989	7,833,979	2,989	7,833,979	......	......	......	......
South Dakota	2,113	2,396,080	649	1,688,869	649	1,688,869	......	......	......	......
Tennessee	12,093	15,372,265	4,093	11,858,518	4,090	11,858,516	......	......	......	......
Texas	30,672	35,724,818	17,619	48,673,086	17,618	48,665,761	1	7,304	......	......
Utah	1,703	1,878,962	1,277	3,018,323	1,277	3,018,323	......	......	......	......
Vermont	1,140	1,109,301	571	1,616,269	571	1,616,269	......	......	......	......
Virginia	11,106	12,162,760	7,435	19,849,618	7,434	19,849,313	......	......	1	305
Washington	7,756	7,452,430	5,886	15,048,567	5,886	15,048,567	......	......	......	......
West Virginia	5,843	6,388,460	2,049	5,006,760	2,049	5,006,760	......	......	......	......
Wisconsin	10,173	8,738,930	4,688	10,535,909	4,688	10,535,909	......	......	......	......
Wyoming	712	710,495	488	1,275,380	488	1,275,380	......	......	......	......

Estimated Selected Expenditures By State—Fiscal Year 1979

State	Compensation and Pension									
	Regular Establishment						Mexican Border Service			
	Deceased Veterans						Living Veterans			
	Total		Service Connected		Special Acts		Total		Service Connected	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount
World Total	48,197	$187,881,486	48,188	$187,819,083	9	$2,372	239	$541,067	5	$44,840
Philippines	725	2,909,080	725	2,909,080	....	....	....	....	....	....
Other Foreign Areas	829	3,468,330	829	3,468,330	....	....	....	....	....	....
Puerto Rico	340	1,205,661	340	1,205,661	....	....	....	....	....	....
Other U.S. Areas	42	182,904	42	182,904	....	....	....	....	....	....
Total U.S.	47,262	180,181,802	47,253	180,179,530	9	2,372	239	541,067	5	44,840
Alabama	1,333	5,007,115	1,333	5,007,115	....	....	2	5,548	....	....
Alaska	44	161,122	44	161,122	....	....	....	....	....	....
Arizona	836	3,066,836	836	3,066,836	....	....	3	3,309	....	....
Arkansas	681	2,376,747	681	2,376,747	....	....	2	3,677	....	....
California	6,086	29,131,053	6,086	29,131,053	....	....	22	41,403	....	....
Colorado	836	3,550,396	836	3,550,396	....	....	2	4,260	....	....
Connecticut	336	1,365,176	336	1,365,176	....	....	4	12,322	....	....
Delaware	100	403,462	100	403,462	....	....	....	....	....	....
District of Columbia	325	1,738,545	325	1,738,545	....	....	1	807	....	....
Florida	3,744	16,277,294	3,744	16,277,294	....	....	11	28,016	....	....
Georgia	1,809	7,106,037	1,809	7,106,037	....	....	2	5,307	....	....
Hawaii	276	1,187,916	276	1,187,916	....	....	....	....	....	....
Idaho	158	565,718	158	565,718	....	....	3	2,810	....	....
Illinois	811	3,281,596	810	3,280,592	1	1,004	8	14,331	....	....
Indiana	686	2,333,637	685	2,333,493	1	144	3	7,718	....	....
Iowa	301	1,067,808	301	1,067,808	....	....	9	25,047	....	....
Kansas	534	1,881,432	534	1,881,432	....	....	2	5,724	....	....
Kentucky	809	2,887,986	808	2,887,842	1	144	3	8,500	....	....
Louisiana	930	3,425,404	930	3,425,404	....	....	1	790	....	....
Maine	258	990,904	258	990,904	....	....	1	1,288	....	....
Maryland	1,090	4,933,415	1,089	4,933,271	1	144	4	8,002	....	....
Massachusetts	1,037	4,151,394	1,036	4,151,250	1	144	6	19,940	1	12,110
Michigan	853	3,013,460	852	3,013,316	1	144	5	12,192	....	....
Minnesota	435	1,466,101	435	1,466,101	....	....	2	4,286	....	....
Mississippi	738	2,651,510	738	2,651,510	....	....	1	425	....	....
Missouri	883	3,306,132	883	3,306,132	....	....	2	10,187	....	....
Montana	118	405,415	118	405,415	....	....	1	107	....	....
Nebraska	257	1,032,800	257	1,032,800	....	....	6	10,023	....	....
Nevada	182	774,285	182	774,285	....	....	....	....	....	....
New Hampshire	190	788,180	190	788,180	....	....	8	20,086	....	....
New Jersey	881	3,405,290	881	3,405,290	....	....	3	4,346	....	....
New Mexico	357	1,407,907	357	1,407,907	....	....	4	5,140	....	....
New York	1,574	6,049,246	1,573	6,049,102	1	144	9	37,386	1	8,037
North Carolina	1,547	5,670,987	1,547	5,670,987	....	....	8	23,149	....	....
North Dakota	65	218,672	65	218,672	....	....	4	5,333	....	....
Ohio	1,176	4,308,937	1,176	4,308,937	....	....	7	22,270	1	4,503
Oklahoma	988	3,810,717	988	3,810,717	....	....	2	6,301	....	....
Oregon	467	1,700,072	467	1,700,072	....	....	3	6,267	....	....
Pennsylvania	1,585	5,834,580	1,585	5,834,580	....	....	13	52,502	2	19,400
Rhode Island	240	1,028,452	240	1,028,452	....	....	4	4,501	....	....
South Carolina	975	3,638,212	975	3,638,212	....	....	6	16,820	....	....
South Dakota	68	257,580	68	257,580	....	....	1	6,284	....	....
Tennessee	1,128	3,936,997	1,127	3,936,853	1	144	4	12,080	....	....
Texas	4,348	18,084,255	4,347	18,083,895	1	360	16	40,789	....	....
Utah	182	777,012	182	777,012	....	....	2	2,086	....	....
Vermont	102	407,753	102	407,753	....	....	2	6,123	....	....
Virginia	2,115	8,835,837	2,115	8,835,837	....	....	4	9,151	....	....
Washington	1,229	5,157,890	1,229	5,157,890	....	....	2	9,841	....	....
West Virginia	400	1,302,821	400	1,302,821	....	....	....	....	....	....
Wisconsin	503	1,749,382	503	1,749,382	....	....	5	15,811	....	....
Wyoming	57	205,462	57	205,462	....	....	1	1,626	....	....

Estimated Selected Expenditures By State–Fiscal Year 1979

State	Compensation and Pension									
	Mexican Border Service								Spanish-American War	
	Living Veterans		Deceased Veterans						Living Veterans	
	Non-Service Connected		Total		Service Connected		Non-Service Connected		Total	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount
World Total	215	$496,227	563	$531,044	3	$15,452	560	$515,592	209	$846,800
Philippines	......	......	......	......	......	......	......	......	8	46,901
Other Foreign Areas	......	......	......	......	......	......	......	......	1	5,900
Puerto Rico	......	......	......	......	......	......	......	......	2	11,000
Other U.S. Areas	......	......	......	......	......	......	......	......	......	......
Total U.S.	215	496,227	563	531,044	3	15,452	560	515,592	198	782,999
Alabama	2	5,546	6	7,882	1	5,347	5	2,535	1	400
Alaska	......	......	......	......	......	......	......	......	......	......
Arizona	3	3,300	5	5,718	......	......	5	5,718	1	4,770
Arkansas	2	3,677	7	8,412	......	......	7	8,412	3	12,831
California	22	41,403	24	20,400	......	......	24	20,400	41	170,882
Colorado	2	4,200	2	2,434	......	......	2	2,434	1	2,137
Connecticut	4	12,322	16	7,312	......	......	16	7,312	2	7,300
Delaware	......	......	3	5,106	......	......	3	5,106	1	1,900
District of Columbia	1	807	......	......	......	......	......	......	4	8,787
Florida	11	26,018	33	29,677	......	......	33	29,677	20	98,651
Georgia	2	5,307	6	7,547	......	......	6	7,547	4	20,530
Hawaii	......	......	......	......	......	......	......	......	......	......
Idaho	3	2,819	......	......	......	......	......	......	......	......
Illinois	8	14,331	9	6,233	......	......	9	6,233	7	28,117
Indiana	3	7,716	24	14,804	......	......	24	14,804	7	29,674
Iowa	9	25,047	19	17,350	......	......	19	17,350	3	8,090
Kansas	2	5,724	7	11,442	......	......	7	11,442	5	18,295
Kentucky	3	8,000	5	5,553	......	......	5	5,553	4	19,861
Louisiana	1	780	4	3,444	......	......	4	3,444	1	1,900
Maine	1	1,200	7	6,143	......	......	7	6,143	1	3,310
Maryland	4	5,883	19	16,320	......	......	19	16,320	......	......
Massachusetts	5	7,830	23	10,721	......	......	23	10,721	4	14,403
Michigan	5	12,192	17	17,973	......	......	17	17,973	2	13,987
Minnesota	2	4,296	15	15,906	......	......	15	15,906	2	9,117
Mississippi	1	425	1	657	......	......	1	657	1	1,898
Missouri	2	10,187	18	16,983	......	......	18	16,983	1	2,137
Montana	1	187	1	3,296	......	......	1	3,296	2	3,605
Nebraska	6	10,023	3	6,638	......	......	3	6,638	2	8,163
Nevada	......	......	......	......	......	......	......	......	1	1,578
New Hampshire	8	20,000	15	9,789	......	......	15	9,789	2	3,225
New Jersey	3	4,345	17	8,857	......	......	17	8,857	5	22,190
New Mexico	4	6,140	6	7,081	......	......	6	7,081	......	......
New York	8	28,748	35	31,220	......	......	35	31,220	13	33,040
North Carolina	8	23,149	16	16,279	......	......	16	16,279	1	3,272
North Dakota	4	6,313	2	2,300	......	......	2	2,300	......	......
Ohio	6	17,677	15	18,233	1	4,757	14	13,476	5	38,903
Oklahoma	2	6,301	10	8,080	......	......	10	8,080	1	7,480
Oregon	3	6,257	15	14,891	1	6,348	14	8,543	2	12,252
Pennsylvania	17	33,093	47	38,416	......	......	47	38,416	9	32,576
Rhode Island	4	4,581	5	1,936	......	......	5	1,936	2	4,328
South Carolina	8	18,820	17	18,638	......	......	17	18,638	1	4,800
South Dakota	1	6,284	2	2,023	......	......	2	2,023	......	......
Tennessee	4	12,690	12	14,278	......	......	12	14,278	8	35,306
Texas	14	40,789	28	38,044	......	......	28	38,044	8	35,402
Utah	2	2,966	3	2,477	......	......	3	2,477	1	849
Vermont	2	6,123	4	2,353	......	......	4	2,353	......	......
Virginia	4	9,151	8	7,845	......	......	8	7,845	2	11,224
Washington	2	9,041	10	10,244	......	......	10	10,244	5	30,176
West Virginia	......	......	7	4,592	......	......	7	4,592	1	3,881
Wisconsin	6	15,611	17	19,223	......	......	17	19,223	2	12,881
Wyoming	1	1,636	......	......	......	......	......	......	......	......

TABLE 85—Continued

Estimated Selected Expenditures By State—Fiscal Year 1979

State	Compensation and Pension									
	Spanish-American War									
	Living Veterans				Deceased Veterans					
	Service Connected		Non-Service Connected		Total		Service Connected		Non-Service Connected	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount
World Total	3	$16,920	206	$829,630	14,945	$19,305,954	151	$602,720	14,794	$18,703,234
Philippines	....	....	8	46,881	371	1,517,286	2	8,217	369	1,509,069
Other Foreign Areas	....	....	1	5,990	156	218,034	....	....	156	218,034
Puerto Rico	....	....	2	11,600	183	202,180	1	3,564	182	198,616
Other U.S. Areas	....	....	....	....	8	11,711	....	....	8	11,711
Total U.S.	3	16,920	195	785,880	14,305	17,355,743	148	590,939	14,157	16,764,804
Alabama	....	....	1	499	183	260,291	2	8,030	181	252,261
Alaska	....	....	....	....	1	3,340	....	....	1	3,340
Arizona	....	....	1	4,770	181	173,134	....	....	181	173,134
Arkansas	....	....	3	12,931	182	221,211	1	3,492	181	217,719
California	....	....	41	170,892	2,296	2,556,448	15	55,583	2,281	2,500,865
Colorado	....	....	1	2,137	183	192,183	1	4,298	182	187,885
Connecticut	....	....	2	7,290	169	175,405	....	....	169	175,405
Delaware	....	....	1	1,500	29	37,381	....	....	29	37,381
District of Columbia	....	....	4	8,707	129	138,699	1	4,538	128	134,161
Florida	....	....	20	98,051	951	1,144,235	23	95,777	928	1,048,458
Georgia	....	....	4	20,530	309	387,387	4	19,589	305	367,798
Hawaii	....	....	....	....	19	25,505	1	3,925	18	21,580
Idaho	....	....	....	....	46	59,521	....	....	46	59,521
Illinois	1	887	6	27,420	504	584,171	2	6,983	502	577,188
Indiana	....	....	7	29,674	414	535,552	10	47,048	404	488,504
Iowa	....	....	3	9,890	145	190,852	2	8,230	143	182,622
Kansas	....	....	5	19,295	186	289,192	....	....	186	289,192
Kentucky	....	....	4	19,881	374	498,214	9	36,387	365	461,827
Louisiana	....	....	1	1,880	176	214,508	1	3,492	175	211,016
Maine	....	....	1	3,319	76	88,832	....	....	76	88,832
Maryland	....	....	....	....	276	332,586	6	19,203	270	313,383
Massachusetts	....	....	4	14,463	365	358,107	2	8,077	363	350,030
Michigan	....	....	2	13,967	389	448,885	4	15,013	385	433,872
Minnesota	....	....	2	9,117	297	268,096	3	12,005	294	256,091
Mississippi	....	....	1	1,880	121	164,961	1	3,492	120	161,469
Missouri	....	....	1	2,137	410	500,069	3	11,946	407	488,123
Montana	....	....	2	3,695	61	72,573	....	....	61	72,573
Nebraska	....	....	2	5,163	89	121,488	1	4,538	88	116,950
Nevada	....	....	1	1,578	36	46,911	....	....	36	46,911
New Hampshire	....	....	2	3,225	62	78,045	3	9,112	59	68,933
New Jersey	....	....	8	22,196	355	382,465	1	3,492	354	378,973
New Mexico	....	....	....	....	62	78,220	1	3,704	61	74,516
New York	....	....	13	33,040	788	981,750	7	28,072	781	953,678
North Carolina	....	....	1	3,272	296	385,549	3	11,521	293	374,028
North Dakota	....	....	....	....	17	23,986	....	....	17	23,986
Ohio	1	13,593	4	25,310	591	736,372	5	25,084	586	711,288
Oklahoma	....	....	1	7,480	298	295,085	1	3,492	297	291,593
Oregon	....	....	2	12,252	298	366,629	1	6,945	297	359,684
Pennsylvania	....	....	9	32,570	589	674,788	3	12,718	586	662,070
Rhode Island	1	2,820	1	1,880	41	52,296	1	3,492	40	48,804
South Carolina	....	....	1	4,474	172	216,457	2	6,302	170	210,155
South Dakota	....	....	....	....	28	43,331	....	....	28	43,331
Tennessee	....	....	8	35,395	471	604,825	8	28,201	463	576,624
Texas	....	....	8	36,402	724	932,770	6	20,836	718	911,934
Utah	....	....	1	849	34	39,637	1	5,172	33	34,465
Vermont	....	....	....	....	47	60,590	2	6,983	45	53,607
Virginia	....	....	2	11,224	351	422,282	6	24,381	345	397,901
Washington	....	....	5	30,170	411	503,264	5	16,288	406	486,976
West Virginia	....	....	1	3,881	118	147,304	....	....	118	147,304
Wisconsin	....	....	2	12,881	190	250,315	1	4,538	189	245,777
Wyoming	....	....	....	....	38	43,827	....	....	38	43,827

Estimated Selected Expenditures By State—Fiscal Year 1979

State	Compensation and Pension											
	Indian Wars						Civil War					
	Deceased Veterans						Deceased Veterans					
	Total		Service Connected		Non-Service Connected		Total		Service Connected		Non-Service Connected	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount
World Total	49	$97,316	1	$2,880	48	$94,440	223	$297,707	6	$33,077	217	$264,720
Philippines												
Other Foreign Areas							1	670			1	670
Puerto Rico												
Other U.S. Areas												
Total U.S.	49	97,316	1	2,880	48	94,440	222	296,919	6	33,077	216	264,042
Alabama							10	10,305			10	10,305
Alaska												
Arizona	3	3,414			3	3,414	2	1,622			2	1,622
Arkansas							7	6,306			7	6,306
California	5	8,804			5	8,804	12	11,688			12	11,688
Colorado							2	1,880			2	1,880
Connecticut							1	1,605			1	1,605
Delaware							1	611			1	611
District of Columbia	1	2,880	1	2,880			3	3,602			3	3,602
Florida	3	3,440			3	3,440	16	29,380	2	8,675	14	20,680
Georgia	1	827			1	827	5	6,623			5	6,623
Hawaii												
Idaho							1	222			1	222
Illinois	3	4,383			3	4,383	8	9,020			8	9,020
Indiana	1	1,700			1	1,700	11	13,695	1	2,848	10	10,847
Iowa							3	3,420			3	3,420
Kansas							5	6,002			5	6,002
Kentucky							6	8,014			6	8,014
Louisiana							2	1,622			2	1,622
Maine							4	4,932			4	4,932
Maryland							3	6,360	1	4,280	2	2,080
Massachusetts	2	1,725			2	1,725	8	8,170			8	8,170
Michigan							8	9,031			8	9,031
Minnesota	4	5,835			4	5,835	3	2,433			3	2,433
Mississippi							8	9,031			8	9,031
Missouri	4	5,056			4	5,056	6	8,143			6	8,143
Montana												
Nebraska	1	1,086			1	1,086						
Nevada												
New Hampshire												
New Jersey							3	1,844			3	1,844
New Mexico	2	1,654			2	1,654	1	611			1	611
New York	2	2,021			2	2,021	5	5,072			5	5,072
North Carolina	2	1,654			2	1,654	8	10,143			8	10,143
North Dakota												
Ohio							11	11,880			11	11,880
Oklahoma							1	611			1	611
Oregon	2	2,087			2	2,087	1	1,086			1	1,086
Pennsylvania	1	827			1	827	5	5,010			5	5,010
Rhode Island							2	2,108			2	2,108
South Carolina	1	802			1	802	3	2,480			3	2,480
South Dakota	4	7,142			4	7,142						
Tennessee	1	2,235			1	2,235	18	28,250	1	8,086	17	20,164
Texas	6	8,127			6	8,127	11	10,420			11	10,420
Utah												
Vermont												
Virginia							6	8,212			6	8,212
Washington							3	2,433			3	2,433
West Virginia							5	7,081			5	7,081
Wisconsin												
Wyoming												

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